Harvard Pilgrim Health Care

Benefit Handbook

The HARVARD PILGRIM POS

For Group Insurance Commission Members

Commonwealth of Massachusetts
Group Insurance Commission

This benefit plan is provided to you by the Group Insurance Commission (GIC) on a self-insured basis. Harvard Pilgrim Health Care has arranged for the availability of a network of health care Providers and will be performing various benefit and claim administration and case management services on behalf of the GIC. Although some materials may reference you as a Member of one of Harvard Pilgrim Health Care's products, the GIC is the insurer of your coverage.

Effective Date: July 1, 2004

INTRODUCTION

Welcome to the Harvard Pilgrim POS (the Plan). Thank you for choosing this Plan to help you meet your health care needs.

The health care services under this Plan are administered by Harvard Pilgrim Health Care (HPHC) through its Provider network. The Harvard Pilgrim POS is a self-insured health benefits plan for the Group Insurance Commission (GIC). The GIC is financially responsible for this Plan's health care benefits. HPHC will perform benefits, claims administration and case management services on behalf of the GIC as outlined in this *Benefit Handbook, Schedule of Benefits* and *Prescription Drug Brochure*

This Point-of-Service (POS) Plan has been designed to offer you the coordinated care and cost advantages of Health Maintenance Organization (HMO) coverage as well as the choice of obtaining Covered Services outside the HMO network. Under the Plan, you can use either HPHC's network of Participating Providers or use Providers of your choice outside of the HPHC network to obtain these services. You have one set of Covered Services under the Plan. If a benefit limit applies, HPHC calculates your utilization for that benefit based on the Covered Services you have received from both *In-Network (Participating Providers)* and *Out-of-Network providers*. Although coverage is provided for both types of Providers, services obtained from *In-Network* Providers (Participating Providers) generally are covered at a lower out-of-pocket cost.

Under this Plan, the GIC provides the covered health care services described in this *Benefit Handbook* and your *Schedule of Benefits*. You must choose a Primary Care Physician (PCP) for yourself and each covered Family member when you enroll. All *In-Network* care must be provided or arranged by your Primary Care Physician (PCP), except in a Medical Emergency or if it is one of the special services that do not require a referral.

If you choose to receive Covered Services from a provider or at a facility that is not a Participating Provider, your benefits will be covered at the *Out-of-Network* level. Your benefits also will be covered at the *Out-of-Network* level if you receive services from a Participating Provider without a referral, when a referral is required.

You may call the HPHC Member Services Department if you have any questions. HPHC values your input and would appreciate any comments or suggestions you may have. Member Services staff are available to help you with questions about the following:

- Selecting a Primary Care Physician
- Your *Benefit Handbook*
- Your *In-Network* and *Out-of-Network* benefits
- Enrollment
- Claims
- Provider information
- Requesting a *Provider Directory*
- Requesting a Member kit
- Requesting ID cards
- Registering a concern

Deaf and hard-of-hearing Members who own or have access to a Teletypewriter (TTY) may communicate directly with the Member Services Department by calling HPHC's TTY machine at **1-800-637-8257**.

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

1-888-333-4742
Internet: www.harvardpilgrim.org

Non-English speaking Members may also call the HPHC Member Services Department with questions at **1-888-333-4742**. HPHC offers free language interpretation services in more than 120 languages.

[Spanish]

Los miembros que no dominan el inglés pueden llamar al Departamento de servicios para miembros de Harvard Pilgrim Health Care al 1-888-333-4742, donde se responderá a sus preguntas. El Plan ofrece un servicio de interpretación gratuito en más de 120 idiomas.

[Russian]

Те, кто не владеет английским языком, могут также получить ответы на свои вопросы, позвонив по телефону 1-888-333-4742 в отдел обслуживания медицинского центра Harvard Pilgrim. Данный план предоставляет бесплатные услуги по обеспечению устного перевода более, чем на 120 иностранных языков.

[Arabic]

كما يستطيع الأعضاء الغير الناطقين باللغة الإنجليزية أن يتصلوا بقسم خدمات الأعضاء بهيئة هارفارد بيلجريم(Harvard Pilgrim) للعناية الصحية ، وذلك للحصول على 1-888-333-4742على الرقم إجابات لاستفساراتهم. ويقدم البرنامج خدمات ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

Os membros que não falarem inglês também podem telefonar para o Departamento dos Serviços de Saúde Harvard Pilgrim para membros através do número 1 888 333 4742, de forma a obterem os esclarecimentos pretendidos. Este plano oferece serviços de interpretação gratuitos em mais de 120 idiomas.

[French]

Harvard Pilgrim Health Care propose des services d'interprétation gratuits dans plus de 120 langues pour répondre aux questions des membres qui ne parlent pas anglais. Pour utiliser ce service, appelez la section des services aux membres au 1-888-333-4742.

[Greek]

Τα Μέλη που δε μιλούν Αγγλικά μπορούν επίσης να τηλεφωνήσουν στο Τμήμα Εξυπηρέτησης Μελών του Harvard Pilgrim Health Care στον αριθμό 1-888-333-4742 για τυχόν ερωτήσεις. Το Πρόγραμμα παρέχει δωρεάν ξενόγλωσσες υπηρεσίες διερμηνείαςγια περισσότερες από 120 γλώσσες.

[Haitian Creole]

Manm yo ki pa pale Angle ka rele Depatman Sèvis Manm Harvard Pilgrim Health Care tou nan 1-888-333-4742 pou jwenn repons a keksyon yo. Plan an ofri sèvis entèpretasyon gratis nan plis ke 120 lang.

[Italian]

I Partecipanti che non parlano inglese possono anche rivolgere le proprie domande al Reparto Servizi Partecipanti dell'Harvard Pilgrim Health Care, chiamando il numero 1-888-333-4742. Il Piano offre servizi di interpretariato gratuiti in oltre 120 lingue.

[Traditional Chinese]

不說英語的會員亦可致電 1-888-333-4742，請 Harvard Pilgrim 醫療保健的 會員服務部門回答所提出的問題。該計劃免費提供120多種語言的翻譯服務。

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ປາກ ພາສາ ອັງກິດ ບໍ່ ເປັນ ກໍ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະແນກ ບໍລິການ ລູກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ **Harvard Pilgrim** ໄດ້ ໂດຍ ໂທ ໄປ ຫາ **1-888-333-4742** ເພື່ອ ຂໍ ຊາຍ ຄໍາ ຕອບ ຂອງ ຄໍາ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ຂໍ ສະເນີ ບໍລິການ ແປ ພາສາ ໃນ ຫລາຍ ກວ່າ **120** ພາສາ ໂດຍ ບ ເສັຽ ຄ່າ ບໍລິການ ໃດໆ ທັງ ສິ້ນ.

[Cambodian]

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Health Care លេខ **1-888-333-4742**
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TABLE OF CONTENTS

I. BENEFIT HANDBOOK

A. ABOUT THE HARVARD PILGRIM POS PLAN

The Plan provides you with two levels of benefits known as *In-Network* coverage and *Out-of-Network* coverage.

You receive *In-Network* coverage when your care is provided or arranged by your Primary Care Physician (PCP), in a Medical Emergency, or if it is one of the special services that does not require a referral and is obtained from a Participating Provider. Participating Providers are under contract to provide care to HPHC Members, and they have agreed to accept HPHC payment plus any applicable Member Cost (Copayment) as payment in full.

You receive *Out-of-Network* coverage when you obtain Covered Services from 1) Non-Participating Providers or 2) Participating Providers without a referral, when a referral is required. HPHC does not have agreements or contracts with Non-Participating Providers. The Plan pays a percentage of the cost of care you receive from Non-Participating Providers and the care you receive from Participating Providers without a referral, when a referral is required. The Plan's percentage payment is based on the Reasonable Charges for such services. You are responsible for the remainder of the Reasonable Charge, any amount above the Reasonable Charge, and any applicable Member Cost.

Your *In-Network* and *Out-of-Network* coverage is described further below. Please see your *Schedule of Benefits* as well as this *Benefit Handbook* to see if a Copayment, Coinsurance or Deductible applies to your coverage.

1. HOW TO USE THIS BENEFIT HANDBOOK

a. Why This Benefit Handbook Is Important

This *Benefit Handbook*, the *Schedule of Benefits*, and the *Prescription Drug Brochure* make up the agreement setting forth the terms of the Plan. If you have eligibility questions, we recommend that you contact the GIC for information.

We wrote this *Benefit Handbook* so that you would understand your coverage. It explains what you must do to obtain coverage for services and what you can expect under the Plan. It is also your guide to the most important things you need to know. These include:

- The requirement that you go to your Primary Care Physician (PCP) for most services to have coverage at the *In-Network* benefit level;
- What is covered;
- What is not covered;
- Any limits or special rules for coverage;
- Any Prior Plan Approval or Notification required;
- Member Cost, which means any Copayments, Coinsurance, Deductibles or Benefit Reductions you must pay; and
- Prescription drug benefits will be listed in the *Prescription Drug Brochure*.

b. Words With Special Meaning

Some words in this *Benefit Handbook* have a special meaning. When we use one of these words, we start it with a capital letter. We list each of these words and their meanings in the Glossary at the end of this *Benefit Handbook*.

c. How To Find What You Need To Know

The Table of Contents will help you find what you need to know.

We also put the most important things first. For example, in this section we tell you how your coverage works. In the next section we tell you what is covered. Most limitations on services appear after the benefit to which they relate in this *Benefit Handbook* and the *Schedule of Benefits*. Any Copayment, Coinsurance, Deductibles or Benefit Reductions for which you are responsible are also listed in this *Benefit Handbook* and the *Schedule of Benefits*.

d. Provider Directory

The Provider Directory lists our Primary Care Physicians (PCPs), specialists and other Participating Providers. Member Services can answer questions about HPHC Providers and their qualifications. You can obtain a copy of the Provider Directory from:

- HPHC's Member Services Department by calling **1-888-333- 4742**, or
- The HPHC Internet site, **www.harvardpilgrim.org**

The online Provider Directory at the HPHC Internet site, **www.harvardpilgrim.org**, provides links to several physician profiling sites including one maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at **www.massmedboard.org**.

Although the Provider Directory lists all Participating Providers, your PCP may refer you only to those Participating Providers with whom the PCP has a working relationship. (See Section I.A.2. on page 7 for further information.)

HPHC cannot guarantee that the physician you choose will continue to participate in HPHC's network for the duration of your coverage. The Providers in the HPHC's Provider network participate through contractual arrangements that can be terminated either by a Provider or by HPHC. In addition, a Provider may leave HPHC's network because of retirement, relocation or other reasons. If your PCP leaves the network for any reason, HPHC will make every effort to notify you at least 30 days in advance, and will help you find a new PCP to meet your health care needs. Please call the Member Services Department at **1-888-333-4742** so that HPHC can help you find a new PCP.

e. Your Schedule of Benefits

Your *Schedule of Benefits* provides a summary of the particular benefits selected by the GIC. You should keep and refer to this *Benefit Handbook* for more detailed information on benefits and coverage.

2. HOW YOUR IN-NETWORK COVERAGE WORKS

Your Plan is subject to the following *In-Network* Member Cost for medical coverage. (**Please note**: *In-Network* Member Cost for mental health and substance abuse services is included in Section I.B.6. on page 24, "Mental Health and Substance Abuse Services"):

a. In-Network Member Cost

Deductible: None

Coinsurance: None

Out-of-Pocket Maximum: None

Office Visit Copayment: $15 per visit per Member up to a maximum of $225 per calendar year. A $15 Copayment applies to the first 15 *In-Network* visits a Member receives each calendar year for any combination of the following covered Outpatient Services: (1) Office visits (excluding office visits for chiropractor and for outpatient mental health and substance abuse services); (2) Chemotherapy; (3) Voluntary second or third surgical opinions; (4) Cardiac rehabilitation; (5) Infertility services; (6) Early intervention services; (7) Physical, occupational, and speech therapy services; and (8) Emergency care in a physician's office. Then, for the rest of the calendar year, the $15 Copayment is waived for those covered outpatient services.

Hospital Inpatient Copayment: $400 per admission up to a maximum of $1,600 per Member per calendar year. The Hospital Inpatient Copayment is limited to a maximum of one Copayment per Member per calendar quarter. If you are admitted as an inpatient more than once per quarter, the subsequent Copayments will be waived by the Plan during that quarter. You will need to call the Member Services Department to request this waiver.

Surgical Day Care Copayment: $75 per admission up to a maximum of $300 per Member per calendar year. The Surgical Day Care Copayment is limited to a maximum of one Copayment per Member per calendar quarter. If you have more than one Surgical Day Care admission per quarter, the subsequent Copayments will be waived by the Plan during that quarter. You will need to call the Member Services Department to request this waiver.

Please note: Hospital Inpatient Copayments and Surgical Day Care Copayments for medical care accumulate only towards the medical Out-of-Pocket Maximum.

b. Choose an In-Network Primary Care Physician (PCP)

When you enroll in the Plan, you must choose a Primary Care Physician (PCP). You select a PCP for yourself and each covered person in your Family. You may choose a different PCP for each Family member. If you do not choose a PCP when you first enroll, or if the PCP you select is not available, we will assign a PCP to you.

A PCP may be a doctor of internal medicine, family practice, general practice or pediatrics. PCPs are listed in the Provider Directory. You may call Member Services to confirm that the PCP you select is available.

If you have not seen your PCP before, we suggest you do the following:

- Call your PCP's office as soon as possible and explain that you are a new Plan Member.
- Make an appointment to see your new PCP so he or she can get to know you and begin taking care of any medical needs you have.
- Ask your previous doctor to send your medical records to your new PCP.

Please do not wait until you are sick to call your PCP. You should get to know your doctor as soon as possible. Your PCP can take better care of you when he or she is familiar with your health status.

You may change your PCP at any time by calling the Member Services Department. Just choose a new PCP from the Provider Directory. We can make the change effective on the date that you call or on a future date. You must inform HPHC when you change your PCP or care may not be covered. If you choose a new PCP, all referrals from your prior PCP become invalid. You will need to get new referrals from your new PCP in order to be covered at the *In-Network* level.

If your PCP stops being a Participating Provider, you will be notified in writing. Whenever possible, HPHC will notify you at least 30 days before the disenrollment of your PCP and will allow continued *In-Network* coverage of benefits as described in this *Benefit Handbook* and your *Schedule of Benefits* for at least 30 days after the PCP's disenrollment. This coverage is provided as long as the PCP has not been disenrolled for quality-related reasons or fraud. You will then need to select a new PCP. As mentioned above, you may select a new PCP by calling the Member Services Department.

c. Your PCP Manages Your In-Network Health Care

1) Call Your PCP for Care

When you need care, call your PCP. Except as stated below, to be covered at the *In-Network* level all care must be either provided by your PCP or arranged by your PCP and provided by a Participating Provider. The only exceptions are:

- Care in a Medical Emergency
- Special services that do not require a referral (See the list of services that do not require a referral located in Section I.A.2.f. on page 9).
- For mental health and substance abuse services you must call the Behavioral Health Access Center at **1-888-777-4742** (See Section I.B.6. on page 24, "Mental Health and Substance Abuse Services", for further information).

Either your PCP or a covering Participating Provider is available to direct your *In-Network* care 24 hours a day. Talk to your PCP and find out what arrangements are available for care after normal business hours. Some PCPs may have covering physicians after hours and others may have extended office/clinic hours. In the event you are unable to reach your PCP or the covering doctor, you may call HPHC for help at **1-888-333-4742** 24 hours a day, 7 days a week.

2) In-Network Hospital and Specialty Care

Your PCP generally uses affiliated Hospitals for inpatient care. This is where you will need to go for *In-Network* coverage, except in a Medical Emergency or when it is Medically Necessary for you to get care at a participating Hospital that is not affiliated with your PCP. In some cases, Notification to, or Prior Plan Approval from, HPHC is required.

When you need specialty care, your PCP will refer you to Participating Providers who are affiliated with the Hospital your PCP uses. These are the Providers you will need to use for *In-Network* coverage unless it is Medically Necessary for you to get care from a Participating Provider who is not affiliated with your PCP. This helps your PCP coordinate and maintain the quality of your care. Participating Providers with recognized expertise in specialty pediatrics, including mental health care, are also covered when Medically Necessary with a referral from your PCP. Your PCP may authorize a standing referral with a specialty care Provider when: 1) the PCP determines that such referral is appropriate; 2) the specialty care Provider agrees to a treatment plan for the Member and provides the PCP with all necessary clinical and administrative information on a regular basis; and 3) the services provided are Covered Services as described in this *Benefit Handbook* and your *Schedule of Benefits*.

Certain specialty services do not require a referral from your PCP. Please see Section I.A.2.f. on page 9, "Services That Do Not Require a Referral" for more information.

If, in the opinion of the Plan, Covered Services are not available through a Participating Provider, and your PCP refers you to a non-Participating Provider with approval from the Plan, these Covered Services will then be provided and paid at the in-network level up to the Reasonable Charge.

If you select a new PCP, all referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new referrals. You must inform HPHC when you change your PCP or care will be covered at the *Out-of-Network* level.

Please note, although the Provider Directory lists all Participating Providers, your PCP may refer you to only those Participating Providers with whom he or she is affiliated.

You must call your PCP's office before going to a Hospital or specialist for *In-Network* coverage, unless you are having a Medical Emergency. The only other exception is for the special services that do not require a referral (see Section I.A.2.f. on page 9).

d. Medical Emergency Services

You are always covered for care in a Medical Emergency. A referral from your PCP is not needed. **In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.**

A Medical Emergency means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to (1) place the health of the Member or another person in serious jeopardy; (2) cause serious impairment to body function; or (3) cause serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions.

Please remember that if you are hospitalized, you must call your PCP within 48 hours, or as soon as you can. Please note that this requirement is met if your attending physician has already given notice to your PCP. Your PCP will arrange for any follow-up care you may need.

e. Coverage for Services When You Are Outside the Service Area

When you are outside the Service Area, your benefits are covered at the *Out-of-Network* level. The only *In-Network* coverage for care outside the Service Area is care needed due to a Medical Emergency.

If you are hospitalized due to a Medical Emergency, you or your designee must call your PCP and HPHC within 48 hours, or as soon as you can. Your PCP will help arrange for any follow-up care you may need. Follow-up care received outside HPHC's network will be covered at the *Out-of-Network* level.

f. In-Network Services That Do Not Require a Referral

While in most cases you will need a referral from your PCP to get *In-Network* coverage from any other Participating Provider, you do not need a referral for the outpatient services listed below. Please note, although these services do not require a referral, any inpatient care or Surgical Day Care Services still requires Prior Plan Approval or Notification, whichever is applicable.

Family Planning Services:

The following services do not require a referral when provided by a participating HPHC obstetrician, gynecologist, certified nurse midwife or family practitioner:

- Family planning consultation, including pregnancy testing
- Contraceptive monitoring
- Tubal ligation
- Voluntary termination of pregnancy

Maternity Services:

The following services do not require a referral when provided by a participating HPHC obstetrician, gynecologist, certified nurse midwife or family practitioner:

- Consultation for expectant parents
- Prenatal and postpartum care
- Prenatal genetic testing (office visits do require a referral)

Gynecological Services:

The following services do not require a referral when provided by a participating HPHC obstetrician, gynecologist, certified nurse midwife or family practitioner:

- Annual gynecological exam
- Medically Necessary evaluations for acute or emergency gynecological conditions
- Follow-up care for obstetrical or gynecological conditions identified during an annual gynecological exam or an evaluation for acute or emergency gynecological conditions
- Cervical cryosurgery
- Colposcopy with biopsy
- Excision of labial lesions
- Laser cone vaporization of the cervix
- Loop electrosurgical excisions of the cervix (LEEP)
- Treatment of amenorrhea
- Treatment of condyloma

Dental Services:

Please note: Only limited coverage is provided for dental care. Please see the benefits in Sections I.B.7.(a) - (f) on pages 26-29, before seeking dental services.

- Extraction of unerupted teeth that are impacted in bone
- Extraction of seven or more permanent teeth
- Removal of tumors or cysts
- Gingivectomies of two or more gum quadrants
- Emergency dental care

For the extraction of unerupted teeth that are impacted in bone, or for the extraction of seven or more permanent teeth, the Participating Provider you can select depends upon where your PCP is located. If your PCP is located at Harvard Vanguard Medical Associates you must obtain this service at one of the following Harvard Vanguard Medical Associates locations:

Braintree	**Peabody**
Burlington	**Post Office Square**
Cambridge	**Quincy**
Chelmsford	**Somerville**
Copley	**Watertown**
Kenmore	**Wellesley**
Medford	**West Roxbury**

If your PCP is located at any other location, you can choose any Participating Provider for *In-Network* coverage of dental care. Participating Providers are listed in the Provider Directory.

Other Services:

- Routine eye exams
- Chiropractic care. Please note that only limited coverage is provided for chiropractic care. Please see the Covered Services section of this *Benefit Handbook* and your *Schedule of Benefits*, before seeking such services.

g. Services Provided by a Disenrolled or Non-Participating Provider

1) Pregnancy

If you are a female Member in your second or third trimester of pregnancy and the Participating Provider you are seeing in connection with your pregnancy is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive *In-Network* coverage for services delivered by the disenrolled Provider, under the terms of this *Benefit Handbook* and your *Schedule of Benefits*, for the period up to, and including, your first postpartum visit.

2) Terminal Illness

A Member with a Terminal Illness whose Participating Provider in connection with such illness is involuntary disenrolled, for reasons other than fraud or quality of care, may continue to receive *In-Network* coverage for services delivered by the disenrolled Provider, under the terms of this *Benefit Handbook* and the *Schedule of Benefits*, until the Member's death.

3) New Membership

If you are a new Member, the Plan will provide *In-Network* coverage for services delivered by a physician who is not a Participating Provider, under the terms of this *Benefit Handbook* and your *Schedule of Benefits*, for up to 30 days from your effective date of coverage if:

The GIC only offers a choice of plans in which the physician is not a Participating Provider, and

- The physician is providing you with an ongoing course of treatment.

Services received from a disenrolled or Non-Participating Provider as described in paragraphs 1, 2, and 3, above, are only covered when the physician agrees to:

- Accept reimbursement from the Plan at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Member in an amount that would exceed the cost sharing that could have been imposed if the Provider had not been disenrolled;
- Adhere to the quality assurance standards of HPHC and to provide the Plan with necessary medical information related to the care provided; and
- Adhere to the Plan's policies and procedures, obtaining prior authorization and providing Covered Services pursuant to a treatment plan, if any, approved by the Plan.

3. HOW YOUR OUT-OF-NETWORK COVERAGE WORKS

Your *Out-of-Network* coverage applies whenever you obtain Covered Services from Providers who are not Participating Providers (also known as Non-Participating Providers) or when you receive services from a Participating Provider without a referral, when a referral is required. The Plan will only pay a percentage of the cost of these Covered Services after you meet a yearly Deductible. You are responsible for paying the balance.

Your Plan is subject to the following *Out-of-Network* Member Cost for medical coverage. (**Please note**: *Out-of-Network* Member Cost for mental health and substance abuse services is included in Section I.B.6. on page 24, "Mental Health and Substance Abuse Services"):

a. Out-of-Network Member Cost

Deductible: $150 per Member per calendar year
$300 per Family per calendar year

The Deductibles for medical care accumulate separately from the mental health and substance abuse care Deductibles.

Please note: The following costs do not apply to the annual Deductible:

- Outpatient emergency room services
- Benefit Reductions
- Hearing aids

Copayments: None

Coinsurance: 20% of Covered Charges after the Deductible is met until the Out-of-Pocket Maximum is reached.

Benefit Reductions: $500 applied to any service that requires Notification or Prior Plan Approval if such Notification or Prior Plan Approval is not received.

Out-of-Pocket Maximum: $3,000 per Member per calendar year, including Coinsurance and Deductible payments.

Separate Out-of-Pocket Maximums exist for medical care and mental health and substance abuse services. **Please note**: The following do not apply to the Out-of-Pocket Maximum:

- Copayments
- Prescription drug Copayments
- Benefit Reductions
- Any charges in excess of the Reasonable Charge.

b. Paying the Out-of-Network Annual Deductible

When you use a Non-Participating Provider, you must first satisfy the Deductible before the Plan begins paying benefits. This *Benefit Handbook* and the *Schedule of Benefits* specifies the Deductible you must satisfy. Each Member must satisfy the per person annual Deductible amount each calendar year. The Family Deductible is met when any combination of Members reaches the Family Deductible amount. When there is a Family Deductible, no Family Member will pay more than the per person annual Deductible. Any Deductible amount incurred for services rendered during the last three (3) months of a calendar year will apply toward the Deductible requirement for the next year, provided that the Member had continuous coverage under the Plan through the GIC at the time the charges in the prior year were incurred and the GIC continues to elect carryover coverage. Deductible amounts for all services are considered incurred as of the date of service.

c. Paying Out-of-Network Coinsurance

After the appropriate Deductible amount is met, you will be responsible for paying the Coinsurance amount. Deductible and Coinsurance amounts are listed in this *Benefit Handbook* and the *Schedule of Benefits.*

d. Charges in Excess of the Reasonable Charges

On occasion, a Non-Participating Provider may charge amounts in excess of the Reasonable Charges. In those instances, you will be financially responsible for the difference between the amount charged by a Non-Participating Provider and the amount the Plan allows.

4. PRIOR APPROVAL PROGRAM

The Prior Approval Program is designed to make sure that the use of certain Covered Services is appropriate. If you use a Participating Provider with a referral, he or she will obtain Prior Plan Approval for you. You or your designee are responsible for obtaining Prior Plan Approval for these services only when you use a Non-Participating Provider or a Participating Provider without a referral when a referral is required. The Prior Approval Program benefits both the Plan and its Members by ensuring the appropriate use of health care services and reducing health care costs and the premiums that must be charged for providing health insurance.

The Prior Approval Program evaluates whether a service is Medically Necessary, including whether it is, and continues to be, provided in an appropriate setting. When Prior Plan Approval is obtained, the Plan will pay up to the full benefit limit stated in this *Benefit Handbook* and the *Schedule of Benefits* for the period and service approved. If Prior Plan Approval is not obtained, whenever you use a Non-Participating Provider or a Participating Provider without a referral when a referral is required, you will be responsible for paying the Benefit Reductions amount stated in this *Benefit Handbook* and the *Schedule of Benefits* in addition to any Copayments, Coinsurance and Deductibles. If the Plan determines at any point that a service is not Medically Necessary, no payments will be made for such services, you will be notified of the Plan's decision and you will be responsible for the entire cost of these services. Prior Plan Approval does not entitle you to benefits not otherwise payable under this *Benefit Handbook*.

To seek Prior Plan Approval, you should call: **1-800-708-4414**, and select Option 4.

a. When To Seek Prior Plan Approval

Prior Plan Approval is required for the procedures and services listed below, to assure coverage of benefits under this *Benefit Handbook* and your *Schedule of Benefits.*

Procedures

- Blepharoplasty - plastic surgery on an eyelid especially to remove fatty or excess tissue. This procedure is sometimes done in conjunction with Ptosis repair when the excess tissue is due to a medical disease.
- Bone marrow transplant/stem cell transplant
- Breast implant removal
- Breast reduction mammoplasty
- Cosmetic procedures (includes scar revision and other potential cosmetic services)
- Gastric stapling/gastric bypass (bariatric surgeries)
- Laminectomy/Discectomy – procedures done on the vertebra in the back usually for disc disease
- Mandibular/Maxillary osteotomy – surgical procedures to realign the jaw, usually for patients with obstructive sleep apnea
- Odontectomy - the removal of teeth by the reflection of a mucoperiosteal flap and excision of bone from around the root or roots before the application of force to effect the tooth removal
- Panniculectomy - a procedure to remove fatty tissue and excess skin from the lower to middle portions of the abdomen. This procedure is indicated in some individual's who have lost considerable weight resulting in loose hanging folds of skin in the abdominal area.
- Port wine stain laser treatment
- Ptosis repair - a procedure to repair the sagging or a drooping of the upper eyelid such that the drooping eyelid impairs the vision as measured by a visual field test
- Rhinoplasty – plastic surgery to change the shape or size of the nose
- Septoplasty – surgical procedure to correct defects or deformities of the nasal septum
- Temporomandibular joint (TMJ) treatment
- Uvulopalatopharyngoplasty (UPPP) - a surgical procedure to remove excess soft tissue surrounding the uvula, soft palate, and tonsils to create a wider opening in the back of the mouth to improve sleep apnea
- Varicose vein excision and ligation

Services

- Advanced reproductive technology (ART)
- Home health care, including home infusion and home hospice
- Infant formula
- Inpatient and Surgical Day Care dental care, extractions and oral or periodontal surgery
- Inpatient rehabilitation care, including inpatient pulmonary rehabilitation
- Inpatient skilled nursing care (SNF)
- Intra-facility admissions (transfers)
- Outpatient enteral nutrition
- Outpatient pulmonary rehabilitation
- Mental Health and Substance Abuse services
- Speech/language therapy
- Vision hardware for special conditions (including post cataract surgery with: 1) an intraocular lens implant or 2) without a lens implant, keratoconus and post retinal detachment surgery)

Please refer to Chart 1 below, to determine who is responsible for requesting approval for facility admissions.

Chart 1

Admitted by:	Admitted to:	Approval Responsibility:
Participating Provider	Participating Hospital	Participating Provider
Participating Provider	Non-Participating Hospital	Member
Non-Participating Provider	Participating Hospital	Member
Non-Participating Provider	Non-Participating Hospital	Member
Participating Provider without a referral when a referral is required	Participating Hospital	Member
Participating Provider without a referral when a referral is required	Non-Participating Hospital	Member

b. How To Seek Prior Plan Approval

To seek Prior Plan Approval, you should call: **1-800-708-4414**, and select Option 4. The following information will be requested:

- The Member's name
- The Member's ID number
- The treating Provider's name, address and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For *Out-of-Network* inpatient admissions the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting Provider's name, address and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

c. What the Prior Approval Program Does

Once the Prior Plan Approval process has been initiated, the Prior Approval Program will evaluate the need for care. You and your attending physician will be notified of the Prior Approval Program's decision to approve or not to approve the Covered Services. During the course of receipt of services the Prior Approval Program will review your care with your Providers to make sure the services continue to be Medically Necessary. All decisions not to approve your services, including admission or the requested length of stay, will be reviewed by a qualified physician.

d. Effect of Prior Plan Approval on Coverage

For services that are approved, Covered Charges will be paid at the applicable rate stated in this *Benefit Handbook* and the *Schedule of Benefits.*

- If Prior Plan Approval is not obtained, you will not be covered if the Plan determines the service was not Medically Necessary.
- If Prior Plan Approval is not obtained, but it is determined that the service is Medically Necessary, the services will be subject to Benefit Reductions, before the Plan begins coverage for the service.

The Benefit Reductions amount will not be applied to the Deductible or Out-of-Pocket Maximum. Prior Plan Approval does not entitle you to benefits not otherwise payable under this *Benefit Handbook*.

When the Prior Approval Program denies a coverage request, it will notify you and your Provider as soon as possible. Prior Plan Approval will be denied if it is determined that the treatment is not Medically Necessary. This might include, for example, (a) when treatment could be provided on an outpatient basis; (b) when the proposed level of inpatient care is not appropriate to your medical condition; or (c) when inpatient care is no longer necessary.

e. Differences of Opinion

If there is a difference of opinion between the Plan and the attending physician about the need for services requiring Prior Plan Approval, the Prior Approval Program will notify both you and your attending physician as soon as possible. The Prior Approval Program will try to reach an agreement with your physician. If an agreement cannot be reached, the Prior Approval Program will not approve the services. Please refer to Section I.E. on page 41, "Appeals and Complaints" for a complete description of the Plan's appeal process.

5. NOTIFICATION

The Plan requires that you or your designee *notify* HPHC prior to receiving certain services from a Non-Participating Provider or a Participating Provider without a referral when a referral is required. If you use a Participating Provider with a referral, he or she will notify HPHC for you.

When Notification is made, the Plan will pay up to the full benefit limit stated in this *Benefit Handbook* and your *Schedule of Benefits*. If Notification is not made in advance, whenever you use a Non-Participating Provider or a Participating Provider without a referral when a referral is required, you will be responsible for paying the Benefit Reductions amount stated in this *Benefit Handbook* and the *Schedule of Benefits* in addition to any Copayments, Coinsurance and Deductibles.

To notify the Plan, you should call: **1-800-708-4414**, and select Option 4.

The following services require Notification:

- A medical admission to an inpatient facility, including admissions for maternity care except for those procedures or services noted in the Prior Plan Approval section.
- Surgical Day Care Services, except for those procedures or services noted in the Prior Plan Approval section
- Human organ transplants, except for bone marrow or stem cell transplants (see Prior Plan Approval)
- Outpatient physical and occupational therapy services

For planned admissions *Out-of-Network*, you must *notify* the Plan in advance. To assure that Notification will be completed in a timely manner, you should contact the Plan at **1-800-708-4414**, and select Option 4, at least five (5) business days in advance of the admission. In the event of a Medical Emergency admission, you or your designee must *notify* the Plan within 48 hours or as soon as possible.

If either the Hospital or physician are Non-Participating, you are responsible for notifying the Plan.

6. WHEN YOU RECEIVE IN-NETWORK AND OUT-OF-NETWORK COVERAGE FOR THE SAME CONDITION

Under some circumstances, you may receive services from both a Participating Provider and a Non-Participating Provider for the same medical condition. When this occurs, your entitlement to *In-Network* or *Out-of-Network* coverage always depends upon the participation status of the individual service Provider and whether you receive a referral when required. For example, you may receive treatment from a physician who is a Participating Provider but choose to obtain tests from a laboratory that is not a Participating Provider. Since your benefits depend upon the participation status of the Provider and obtaining a referral when required, the physician's service would be covered at the *In-Network* coverage level when a referral was obtained and the laboratory would be covered at the *Out-of-Network* coverage level.

Please refer to Chart 2, located on the next page, as a guideline of the benefit payment levels when using various Provider combinations.

Chart 2

	Admitted by: **Participating Provider with a referral**	Admitted by: **Non-Participating Provider or a Participating Provider without a referral**
Admitted to: **Participating Hospital**	Hospital - *In-Network* benefit payment level Physician - *In-Network* benefit payment level	Hospital – *In-Network* benefit payment level Physician - *Out-of-Network* benefit payment level
Admitted to: **Non-Participating Hospital**	Hospital - *Out-of-Network* benefit payment level Physician - *In-Network* benefit payment level	Hospital – *Out-of-Network* benefit payment level Physician - *Out-of-Network* benefit payment level

Please note: If, in the opinion of the Plan, Covered Services are not available through a Participating Provider, and your PCP refers you to a non-Participating Provider with approval from the Plan, these Covered Services will then be provided and paid at the in-network level up to the Reasonable Charge.

B. COVERED SERVICES

In this section, you will find just about everything you need to understand your Plan benefits. This includes: what is covered, what is not covered, and any limitations on coverage. Each Covered Service section first describes your basic benefit, then will tell you how to receive the service either *In-Network* or *Out-of-Network*. For example, for *In-Network* coverage it will tell you if a service requires a referral from your PCP, or if your PCP needs to provide Notification or obtain Prior Plan Approval for coverage based on your medical condition. For *Out-of-Network* coverage it will tell you if a service requires you to *notify* the Plan of your need for certain services or if you need to obtain Prior Plan Approval from the Plan.

You have one set of Covered Services per calendar year, unless otherwise noted. If the Covered Service has benefit limits, you are restricted to those limits regardless of whether you choose to receive care *In-Network* or *Out-of-Network* or both. For example, if the Covered Service is limited to ten visits and you receive nine visits *In-Network* and one visit *Out-of-Network*, then you will have reached your benefit limit and will no longer have coverage for that benefit for the remainder of that calendar year.

1. BASIC REQUIREMENTS FOR COVERAGE

To be covered, all services and supplies must be:

- Medically Necessary;
- Received while a Member of the Plan;
- Listed in Section I.B. on pages 16-38, "Covered Services" and not excluded in Section I.B.9. on pages 37-38, "Exclusions."

Please see your *Schedule of Benefits* as well as this *Benefit Handbook* for any special limits or exclusions from coverage.

In-Network services must be provided or arranged by your PCP or obtained from a Participating Provider with a referral. The only exceptions are care needed in a Medical Emergency or care for one of the special services that do not require a referral listed in Section I.A.2.f. on page 9.

Out-of-Network services may be provided by a Non-Participating Provider or a Participating Provider without a referral, when a referral is required.

2. INPATIENT CARE

The Plan covers the following inpatient services:

- Semi-private room and board
- Doctor visits, including consultation with specialists
- Medications
- Lab and x-ray services
- Intensive care
- Surgery, including related services
- Anesthesia, including the services of a nurse-anesthetist
- Radiation therapy
- Physical therapy, occupational therapy and speech therapy
- Private duty nursing

The type of coverage that applies to a Hospital admission depends on the participation status of both the admitting physician and the Hospital and whether or not a referral was obtained for the service. If the Hospital or physician is a Non-Participating Provider or if a referral is not obtained for services provided by a Participating Provider, coverage is at the *Out-of-Network* benefit payment level. If you are admitted to a participating Hospital by a Participating Provider with a referral, payment to both is made at the *In-Network* benefit payment level. Please refer to Chart 3 on page 17 as a guideline of the benefit payment levels when using various Provider combinations.

All inpatient admissions including Surgical Day Care Services require you or your designee to *notify* HPHC in advance of the need for such services. An admission includes the transfer from one inpatient facility to another.

In-Network coverage applies when you use a participating Hospital. Your PCP or specialist will arrange the admission and provide Notification or obtain Prior Plan Approval, whichever is appropriate.

Out-of-Network coverage applies when you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required. You are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, in advance of such admission by calling: **1-800-708-4414**, and select Option 4.

For further information about the Prior Plan Approval process or Notification process, please refer to Sections I.A.4.a. on page 12 or I.A.5. on page 14.

Chart 3

	Admitted by: **Participating Provider with a referral**	Admitted by: **Non-Participating Provider or a Participating Provider without a referral**
Admitted to: **Participating Hospital with a referral**	Hospital - *In-Network* benefit payment level Physician - *In-Network* benefit payment level	Hospital – *In-Network* benefit payment level Physician - *Out-of-Network* benefit payment level
Admitted to: **Non-Participating Hospital or Participating Hospital without a referral**	Hospital - *Out-of-Network* benefit payment level Physician - *In-Network* benefit payment level	Hospital – *Out-of-Network* benefit payment level Physician - *Out-of-Network* benefit payment level

Please note: If, in the opinion of the Plan, Covered Services are not available through a Participating Provider, and your PCP refers you to a non-Participating Provider with approval from the Plan, these Covered Services will then be provided and paid at the in-network level up to the Reasonable Charge.

Specific inpatient care benefits are described below.

a. Acute Hospital Care

The Plan covers acute Hospital care to the extent Medically Necessary. There is no limit on the number of Medically Necessary days covered.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, your PCP or specialist will arrange the admission and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No charge after Member pays $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

b. Skilled Nursing Facility Care

The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Such coverage is provided only when you need daily skilled nursing care or rehabilitative services that must be provided in an inpatient setting. These services are limited to a combined maximum with services in an Inpatient Rehabilitation facility up to $10,000 per Member per calendar year.

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the admission and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

c. Inpatient Rehabilitation Services

The Plan covers care in a health care facility licensed to provide rehabilitative care on an inpatient basis. Rehabilitative care includes physical, speech and occupational therapies. These services are limited to a combined maximum with services in a Skilled Nursing Facility up to $10,000 per Member per calendar year.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the admission and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS FOR ALL INPATIENT CARE:

- Personal items, including telephone and television charges
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Rest or Custodial Care
- Blood or blood products
- Charges after your Hospital discharge
- Charges after the date on which your membership ends

3. OUTPATIENT CARE

The Plan covers outpatient care that you receive from a Provider at a doctor's office, clinic or Hospital.

See the *Schedule of Benefits* as well as this *Benefit Handbook* for detailed information on payment amounts and your financial obligations.

For *In-Network* coverage, the Plan covers outpatient care that you receive from your PCP or upon referral from your PCP to a Participating Provider. The only time your care does not need to be provided or arranged by your PCP is in a Medical Emergency or if it is one of the special services that do not require a referral listed in Section I.A.2. on page 7, "How Your In-Network Coverage Works."

For *Out-of-Network* coverage, the Plan covers outpatient care that you receive from either a Non-Participating Provider or from a Participating Provider without a referral.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per office visit for outpatient care, except as otherwise listed.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Outpatient Department visits:

- *In-Network*: No Member charge, except as otherwise listed.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Emergency Room visits:

- *In-Network:* No Member charge after $50 Copayment per ER visit. This Copayment is waived if you are admitted.
- *Out-of-Network:* No Member charge after $50 Copayment per ER visit. This Copayment is waived if you are admitted.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

a. Preventive Care in the Doctor's Office

The Plan covers preventive care according to your individual medical needs. Your PCP generally provides these services. Covered preventive care includes: physical examinations; immunizations; vision and hearing screening; mammograms; health education; and nutritional counseling (limited to 3 visits per calendar year except as needed for the treatment of diabetes).

Also covered are Medically Necessary diagnostic screening and tests, including, but not limited to, the following: hereditary and metabolic screening at birth; newborn hearing screening test; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, and urinalysis; annual cytological screenings; and mammograms, including a baseline mammogram for women between the ages of thirty-five and forty, and an annual mammogram for women forty years of age and older.

Covered pediatric care includes: physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals: at least six visits per year are covered for a child from birth to age one. At least three visits per year are covered for a child from age one to age two. At least one visit per year is covered for a child from age two to age six.

1) Routine Physical Examinations

The Plan covers routine physical examinations. School, sports, camp and premarital examinations are also covered.

For *In-Network* coverage, your PCP will provide the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per office visit. There is no Member charge for mammograms or Pap smears when provided as part of a physical examination.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Exams, other than those stated above, including insurance, licensing, and employment exams

2) Eye Examinations

The Plan covers one routine eye examination in each 24-month period with an ophthalmologist or optometrist

For *In-Network* coverage, you do not need a referral but you must obtain services from a Participating Provider. However, the Participating Provider you can select depends upon where your PCP is located. Please see Section I.A.2. on page 7, "How Your In-Network Coverage Works," for more information.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network:* No Member charge after $15 Copayment per visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

b. Sick or Injured Care

The Plan covers care when you are sick, injured or require medical management for a chronic condition. Services include, but are not limited to, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth, diagnosis and treatment, injections, radiation therapy, diagnostic tests and x-rays, dressings, sutures, and casting.

For *In-Network* coverage, your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a referral for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

c. Emergency Room Care

In the event of a Medical Emergency, you are covered at the *In-Network* benefit payment level in a Hospital emergency room.

For *In-Network* coverage, you must call your PCP before going to an emergency room except in a Medical Emergency. Please remember for *In-Network* coverage, all follow-up care must be provided or arranged by your PCP.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: No Member charge after $50 Copayment per ER visit. This Copayment is waived if you are admitted.
- *Out-of-Network:* No Member charge after $50 Copayment per ER visit. This Copayment is waived if you are admitted.

RELATED EXCLUSIONS:

- *In-Network* benefits for follow-up care, unless provided or arranged by your PCP

d. Diagnostic Lab and X-Rays

The Plan covers outpatient diagnostic laboratory and x-ray services to diagnose illness, injury, or pregnancy.

The Plan also covers human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health).

For *In-Network* coverage, your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a referral for the care you need.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

e. Physical and Occupational Therapies

Outpatient physical and occupational therapies are each covered up to 90 consecutive days per condition. Services are covered only when needed to improve your ability to perform Activities of Daily Living and when, in the opinion of your Provider, there is likely to be significant improvement in your condition within that time period. Your Provider will order therapy for you based on your condition and needs.

Physical and occupational therapies are also covered under your inpatient hospital, home health and hospice benefits. When such therapies are part of an approved home care treatment plan they are not subject to the outpatient benefit of 90 consecutive days noted above. However, services are still subject to the criteria for home health care. (Please see the home health and hospice care benefits further in this section for information on in-home coverage.)

Notification:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and provide Notification.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for providing Notification by calling **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing
- Services for problems of school performance
- Sensory integrative praxis tests
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation

f. Speech, Language and Hearing Services

The Plan covers diagnosis and treatment of speech, hearing and language disorders provided by speech-language pathologists and audiologists to the extent Medically Necessary. If you require speech therapy, your Provider will order therapy for you based on your condition or needs.

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services, in paragraph g. below
- Services for problems of school performance
- Sensory integrative praxis tests
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation

g. Early Intervention Services

The Plan covers early intervention services when Medically Necessary. Early intervention coverage is provided both *In-Network* and *Out-of-Network* as described below. Coverage is provided for Members from birth through the Member's third birthday. The Plan covers up to $3,200 per calendar year, with a lifetime maximum of $9,600. Covered Services include:

- Screening and assessment of the need for services
- Physical, speech, and occupational therapy
- Psychological counseling
- Nursing care

For *In-Network* coverage, you must use a Participating Provider. Your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a necessary referral for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

h. Outpatient Surgery

The Plan covers outpatient ambulatory surgery or Surgical Day Care Services, including related services.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, your PCP or specialist will arrange the admission and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**, and select Option 4.

Member Cost:

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

i. Second Opinions

There may be times when you want a second opinion. The Plan will cover a second opinion from a licensed physician regarding proposed treatment or diagnosis.

For *In-Network* coverage, your PCP will refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a

Participating Provider without a referral for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

j. Allergy Treatment

The Plan covers allergy testing, antigens and allergy treatments.

For *In-Network* coverage, your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a referral for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit. No Member charge for office visits when only for administration of allergy injections.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

4. FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT

a. Family Planning Services

The Plan covers family planning services including pregnancy testing and genetic counseling. The following services can be obtained from any Provider without a referral for office visits.

- Annual gynecological examination
- Family planning consultation
- Pregnancy testing
- Voluntary sterilization, including tubal ligation.
- Voluntary termination of pregnancy
- Contraceptive monitoring
- Genetic counseling
- Vasectomy (requires PCP referral for coverage at the *In-Network* level)

For *In-Network* coverage, you must use a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a necessary referral for the care you need.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per visit. No Member charge for contraceptive devices or injections provided as part of an office visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization

b. Infertility Treatment

Infertility is a medical condition defined as the inability of a presumably healthy individual to conceive or produce conception during a period of one year. The advanced reproductive technologies (ART) are covered up to a maximum of 5 attempts.

The Plan covers the following infertility treatments:

- Consultation and evaluation
- Laboratory tests
- Artificial insemination (AI), including related sperm procurement and banking
- Advanced reproductive technologies, including,

but not limited to, in-vitro fertilization including embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per office visit for outpatient care, except as otherwise listed.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization
- Any infertility treatment related to voluntary sterilization or its reversal
- Infertility treatment for Members who are not medically infertile
- Any form of surrogacy

5. MATERNITY CARE

The Plan covers the following maternity care services:

- Prenatal exams
- Diagnostic tests
- Diet regulation
- Prenatal genetic testing (office visits do require a referral for coverage at the *In-Network* level)
- Post-partum care
- Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If the inpatient stay is less than 48 hours (or 96 hours in the case of a cesarean delivery) the Plan will cover at least one home visit by a registered nurse or certified nurse midwife.
- Nursery charges for routine services provided to a healthy newborn.

Any maternity care, including delivery, from a Non-Participating Provider will be covered at the *Out-of-Network* benefit level.

When using a Non-Participating Provider, you may call the Brighter Infant Beginnings Program (BIB), at **1-800-742-2423** after your first prenatal visit. The BIB program was designed to meet the needs of each individual by providing a variety of support services throughout pregnancy and delivery.

Notification:

- If you are using a Participating Provider, your PCP or specialist will arrange the admission and provide Notification.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for providing Notification by calling **1-800-708-4414**, and select Option 4.

Member Cost:

Office visits:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.

- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Planned home births

6. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

If you need mental health care or substance abuse services, you must call the Behavioral Health Access Center at **1-888-777-4742**. The phone line is staffed by licensed mental health clinicians. They will assist you in finding appropriate Providers and arranging the services you require. Your Plan covers inpatient, intermediate and outpatient services as described below.

HPHC requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity of mental health services will be made in consultation with licensed mental health clinicians.

Prior Plan Approval:

- For all *In-Network* coverage, you must call the Behavioral Health Access Center. The Behavioral Health Access Center will assist you in determining the type of care you need, finding appropriate Participating Providers, and arranging the services you require. To contact the Behavioral Health Access Center, please call **1-888-777-4742**.
- For all *Out-of-Network* coverage, you must obtain Prior Plan Approval if you are using a Non-Participating Provider. The Prior Approval process is initiated by calling**: 1-888-777-4742**. Further information about Prior Plan Approval may be found in Section I.A.4.a. on page 12.

Member Cost and Benefit Reductions:

Deductible:

- *In-network:* None
- *Out-of-Network:* $150 per Member, $300 per Family

The Deductibles for mental health and substance abuse services accumulate separately from medical care.

Out-of-Pocket Maximum:

- *In-Network:* $1,000 per Member, $2,000 per Family
- *Out-of-Network*: $3,000 per Member per calendar year

Please note: *In-Network* Out-of-Pocket Maximums include Copayments and exclude prescription drug Copayments and Benefit Reductions. *Out-of-Network* Out-of-Pocket Maximums included Deductible and Coinsurance and exclude Copayments, prescription drug Copayments, Benefit Reductions, and any charges in excess of the Reasonable Charge. Separate Out-of-Pocket Maximums exist for mental health and substance abuse services and medical care.

Benefit Reductions:

- *In-Network:* None
- *Out-of-Network*: $200 applied to any service that requires Prior Plan Approval if such Prior Plan Approval is not received.

a. Inpatient Services - Mental Health

- Inpatient care is covered when it is Medically Necessary.
  - Services are covered in a general or psychiatric Hospital without day limits.

Member Cost and Benefit Reductions:

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $200 Hospital Inpatient Copayment. If you are admitted as an inpatient more than once per quarter, the subsequent Copayments will be waived by the Plan during that quarter. You will need to call the Member Services Department to request this waiver.
- *Out-of-Network***:** $150 per admission.

Coinsurance:

- *In-Network:* None
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible and Hospital Inpatient Copayment, then Member pays 20% and any balance above the Reasonable Charge.

b. Inpatient Services - Substance Abuse

- Inpatient rehabilitative care for substance abuse is covered when it is Medically Necessary.

- Services are covered in a general Hospital or substance abuse facility without day limits.

- Inpatient detoxification is covered as long as it is Medically Necessary.

Member Cost

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $200 Hospital Inpatient Copayment. If you are admitted as an inpatient more than once per quarter, the subsequent Copayments will be waived by the Plan during that quarter. You will need to call the Member Services Department to request this waiver.
- *Out-of-Network*: $150 Hospital per admission.

Coinsurance:

- *In-Network:* None
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible and Hospital Inpatient Copayment, then Member pays 20% and any balance above the Reasonable Charge.

c. Outpatient Services - Mental Health and Substance Abuse Services

The Plan covers outpatient mental health care and substance abuse services. Coverage is provided for evaluation, diagnosis, treatment and crisis intervention.

Member Cost:

Office Visits

- *In-Network*:
  - Visits 1-4 (Individual or Group therapy): No Member charge.
  - Individual therapy visits 5 and over: No Member charge after $15 Copayment.
  - Group therapy visits 5 and over: No Member charge after $10 Copayment.

This Copayment does not apply to the limit on office visit Copayments described in Section I.A.2. on page 7.

- *Out of network*:
  - Visits 1-15 (Individual or Group therapy): The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.
  - Visits 16 and over (Individual or Group therapy): The Plan pays 50% of the Reasonable Charge after the Deductible, then Member pays 50% and any balance above the Reasonable Charge.

d. Intermediate Mental Health and Substance Abuse Services

The Plan covers intermediate mental health and substance abuse services. Intermediate mental health and substance abuse services are an acute level of care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization.

Intermediate care services when authorized may include detoxification, acute residential treatment (long-term residential treatment is not covered), crisis stabilization, day/partial hospital programs, structured outpatient programs, 24-hour intermediate care facilities, and therapeutic foster care.

Member Cost:

- *In-Network*: No Member charge.
- *Out of network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Services for problems of school performance
- Mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health.

e. Psychopharmacological Services

The Plan covers outpatient detoxification and psychopharmacological services to the extent they are Medically Necessary. The Behavioral Health Access Center will refer you for care, as described previously in this *Benefit Handbook*.

Member Cost:

- *In-Network*: No Member charge after $5 Copayment per visit.

- *Out of Network*: Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

f. Psychological Testing and Neuropsychological Assessment

The Plan covers psychological testing and neuropsychological assessment to the extent they are Medically Necessary. A Participating Provider must refer you for such testing and obtain HPHC approval for coverage.

For *In-Network* coverage, your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a referral for the care you need.

Member Cost:

- *In-Network*: No Member charge.
- *Out of Network*: Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Sensory integrative praxis tests

g. Enrollee Assistance Program:

The Plan covers up to four visits per Member per calendar year with an Enrollee Assistance Program (EAP) benefit provided through the Plan's contractor, ValueOptions. There is no Member Copayment for these services.

The EAP program can help with the following types of problems:

- Divorce, separation or breakup of a relationship
- Helping children adjust to new family members and step family challenges
- Death of a friend or family member
- Communication problems
- Conflicts or relationship issues at work
- Stress due to legal or financial difficulties
- Child or elder care services
- Traumatic events

To use your EAP benefit call **1-800-678-9162**. You will be referred to an EAP provider and/or other specialized community resources (e.g. attorneys, family mediators, dependent care services), as applicable. Subscribers and their eligible Dependents are eligible for EAP services. ValueOptions may recommend mental health and substance abuse services available through your Plan if the problem seems to require more extensive assistance than EAP services provide.

Note: Your EAP benefits are not eligible for appeals rights as set forth in this *Handbook.*

7. DENTAL SERVICES

The Plan covers only the limited dental services described below.

The benefits described in Sections a – d are provided only when the Member has a serious medical condition, including but not limited to, hemophilia or heart disease, that makes it essential that he or she be admitted to a general Hospital as an inpatient or to a Surgical Day Care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely.

a. Extraction of Impacted Teeth

The Plan covers the extraction of unerupted teeth impacted in bone. Pre-operative and post-operative care, x-rays and anesthesia are covered.

For coverage at the *In-Network* level, the Participating Provider you can select depends upon where your PCP is located. You do not need a referral but you must obtain services from a Participating Provider. Please see Section I.A.2.f. on page 9 for more information.

For coverage at the *Out-of-Network* level, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures

b. Extraction of Seven or More Permanent Teeth

The Plan covers the extraction of seven or more permanent teeth during one visit or such additional related visits determined by the Plan.

For coverage at the *In-Network* level, the Participating Provider you can select depends upon where your PCP is located. Please see Section I.A.2.f. on page 9 for more information

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

c. Removal of Tumors or Cysts

The Plan covers the excision of radicular cysts involving the roots of three or more teeth. For *In-Network* coverage, your PCP will refer you for such care.

For *In-Network* coverage, you do not need a referral but you must obtain services from a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.

- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

d. Gingivectomies of Two or More Gum Quadrants

The Plan covers gingivectomies (including osseous surgery) of two or more gum quadrants when Medically Necessary.

For *In-Network* coverage, you need a referral from your PCP.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

e. Emergency Dental Care

The Plan covers emergency dental care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within 72 hours of injury.

Only the following services are covered:

- Initial first aid (trauma care)
- Reduction of swelling
- Pain relief
- Covered non-dental surgery
- Non-dental diagnostic x-rays
- Extraction of teeth needed to avoid infection of teeth damaged in the injury
- Suturing and suture removal
- Re-implanting and stabilization of dislodged teeth
- Re-positioning and stabilization of partly dislodged teeth
- Medication received from the Provider

For *In-Network* coverage, all follow-up care must be provided or arranged by your PCP.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

RELATED EXCLUSIONS:

- Fillings
- Crowns
- Gum care, including gum surgery
- Braces
- Root canals
- Bridges
- Dentures
- Bonding

Member Cost:

Office visits:

- *In-Network*: No Member charge.
- *Out-of-network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Emergency Room:

- *In-Network*: No Member charge after $50 Copayment per ER visit.
- *Out-of-network*: No Member charge after $50 Copayment per ER visit.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

f. Oral Surgery Procedures

The Plan covers oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal of benign or malignant tumors, to the same extent as other surgical procedures described in this *Benefit Handbook*.

For *In-Network* coverage, you must get a referral from your PCP.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Fillings
- Crowns
- Gum care, including gum surgery
- Braces
- Root canals
- Bridges
- Dentures
- Bonding

8. OTHER SERVICES

a. Home Health Care

When you are homebound for medical reasons, the Plan covers the home health care services stated below on an intermittent basis only. To be eligible, your doctor must find that both skilled nursing care and physical therapy are an essential part of active treatment. There must also be a defined medical goal that your doctor expects you will meet.

When you qualify for skilled nursing care and physical therapy as stated above, the Plan also covers the following, when Medically Necessary:

- Occupational therapy
- Speech therapy

- Durable medical equipment and supplies
- Medical social services
- Nutritional counseling
- Services of a home health aide

Please note that physical and occupational therapies covered under the home health care benefit are not subject to the outpatient benefit of 90 consecutive days per condition. However, services are still subject to the criteria for home health care.

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Private duty nursing
- Continuous home health care

b. Hospice Services

The Plan covers hospice services for a terminally ill Member with a life expectancy of 6 months or less. Care may be provided at home or on an inpatient basis. (Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to five days every three months not to exceed 14 days per calendar year. Inpatient care is only covered when Medically Necessary to control pain and manage acute and severe clinical problems which cannot be managed in a home setting.)

Covered services include: physician services; nursing care; social services; counseling services; care to relieve pain; home health aide services; occupational, physical, speech, and respiratory therapy; medical supplies; appliances; drugs which cannot be self-administered; and respite care.

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Please note: If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

c. House Calls

The Plan covers house calls from a licensed physician to the extent they are Medically Necessary.

For *In-Network* coverage, your PCP will provide or arrange the care you need.

For *Out-of-Network* coverage, you may use the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

d. Durable Medical and Prosthetic Equipment

The Plan covers durable medical equipment including prosthetic devices when Medically Necessary and ordered by your doctor. The cost of the repair and maintenance of covered equipment is also covered.

Coverage is only available for:

- The least costly equipment or prosthesis adequate to allow you to do Activities of Daily Living; and

- One item of each type of equipment that meets the Member's need. No back-up items or items that serve duplicate purposes are covered. For example, the Plan covers a manual or an electric wheelchair, not both.

In order to be covered, all equipment must be:

- Able to withstand repeated use
- Not generally useful in the absence of disease or injury
- Suitable for home use
- Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part. (This does not apply to prostheses.)

Covered equipment includes:

- Respiratory equipment
- Certain types of braces
- Oxygen and oxygen equipment
- Hospital beds
- Wheelchairs
- Walkers
- Crutches
- Canes
- Insulin pumps and blood glucose monitors, including voice-synthesizers and visual magnifying aids when Medically Necessary for their use

Covered prostheses include:

- Artificial arms and legs, other than electronic and myoelectric devices
- Artificial eyes
- Breast prostheses, including replacement every 2 years and mastectomy bras up to 3 per 12-month period
- Ostomy supplies
- Wigs, up to $350 per Member per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury
- Therapeutic molded shoes, and foot orthotics needed to prevent or treat complications of diabetes

For *In-Network* coverage, your PCP will provide or arrange for the care you need.

For *Out-of-Network* coverage, the Non-Participating Provider of your choice will provide or arrange for the care you need.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

The following items are not covered:

- Exercise equipment
- Therapeutic molded shoes, and foot orthotics, except for severe diabetic foot disease
- Dentures
- Derotation knee braces
- Electronic and myoelectric artificial limbs
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft
- Any devices or special equipment needed for sports or occupational purposes
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment

e. Ambulance Transport

In the event of a Medical Emergency, the Plan covers ambulance transport to the nearest Hospital that can provide the care you need. The Plan also covers Medically Necessary transfers from one health care facility to another.

For *In-Network* coverage, except in a Medical Emergency, ambulance transport is covered only when arranged by a Participating Provider.

For *Out-of-Network* coverage, the Non-Participating Provider of your choice will arrange for the care you need.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

f. Reconstructive Surgery and Procedures

For purposes of this *Benefit Handbook*, reconstructive surgery is any procedure to repair improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease.

The Plan covers surgery for post-mastectomy coverage including:

1) reconstruction of the breast on which the mastectomy was performed;
2) surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**, and select Option 4.
- Please see the list in Sections I.A.4.a. and I.A.5., pages 12-14, for details regarding which services require Prior Plan Approval and Notification.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

g. Kidney Dialysis

The Plan covers kidney dialysis on an inpatient or outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, drugs and equipment necessary for dialysis. Installation of home equipment is covered up to $300 in a Member's lifetime.

Prior Plan Approval

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414,** and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

h. Human Organ Transplants

The Plan covers Medically Necessary human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer.

The Plan covers the following services when the recipient is a Member of the Plan:

- Care for the recipient
- Donor search costs through established organ donor registries
- Donor costs that are not covered by the donor's health plan

If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, your PCP or specialist will arrange the services you need and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider or the admitting physician is a Participating Provider and a referral was not received as required, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**, and select Option 4.
- Please see the list in Sections I.A.4.a. and I.A.5., pages 12-14, for details regarding which services require Prior Plan Approval or Notification.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Human organ or bone marrow transplants that are Experimental or Unproven

i. Special Infant Formulas and Low Protein Foods

The Plan covers the following:

- Special infant formulas, including those formulas approved by the Department of Public Health
- Formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility, or chronic intestinal pseudo-obstruction
- Low protein foods for inherited diseases of amino and organic acids up to $2,500 per Member per calendar year.

Prior Plan Approval:

- If you are using a Participating Provider, your PCP will provide or arrange for the care you need.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling: **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

j. Diabetes Treatment

The Plan covers the following services for persons with diabetes to the extent Medically Necessary:

a. Therapeutic molded shoes and inserts for severe diabetic foot disease prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; dosage gauges;

injectors; lancet devices; voice synthesizers; and visual magnifying aids.

b. Blood glucose monitors, insulin pumps and supplies and infusion devices.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network*: No Member charge.

c. Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips.

For *In-Network* coverage you must get a prescription from your Provider and present it at a HPHC participating pharmacy. A list of HPHC participating pharmacies is available from the Member Services Department

For *Out-of-Network* coverage, the Non-Participating Provider of your choice will provide or arrange for the care you need.

Member Cost:

- *In-Network*: $10 Copayment for Generic items, a $20 Copayment for Select Brand items and a $40 Copayment for Non-Select Brand items for a 30-day supply.
- *Out-of-Network*: $10 Copayment for Generic items, a $20 Copayment for Select Brand items and a $40 Copayment for Non-Select Brand items for a 30-day supply.

k. Cardiac Rehabilitation

The Plan covers cardiac rehabilitation as required by Massachusetts law. For *In-Network* coverage, you must be referred by your PCP to a Participating Provider. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

For *In-Network* coverage, your PCP will provide or arrange for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a necessary referral for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

The Plan covers approved Coronary Artery Disease (CAD) programs for all Plan Members. These programs are designed to help Members who meet the program's defined criteria for CAD by supporting them in making lifestyle changes that can reduce cardiac risk factors. This benefit is available to Members with a history of heart disease.

For information on these programs:

- Members enrolled with a PCP at one of the Harvard Vanguard Medical Associates health sites can call **(617) 421-2560**.
- Members enrolled with a PCP in Western Massachusetts should contact their physician for a referral.
- All other Members with PCPs in Massachusetts should contact Specialty Case Management at **1-888-888-4742**, ext. 38583.

Member Cost:

- *In-Network*: 10% Coinsurance of Reasonable Charge.
- *Out-of-Network*: Not Covered

l. Temporomandibular Joint Dysfunction (TMJ) Services

Your coverage for TMJ services is limited to medical services only. The Plan covers only the following services:

- Initial consultation
- X-rays
- Physical therapy, subject to the visit limit for outpatient physical therapy
- Surgery

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

Office visits:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: No Member charge after $75 Surgical Day Care Copayment per admission.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: No Member charge after $400 Hospital Inpatient Copayment.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- All services of a dentist for Temporomandibular Joint Dysfunction (TMD), except oral surgery

m. Prescription Drug Coverage

Please see the *Prescription Drug Brochure* included in your Member kit. Your prescription drug Copayments are listed on your ID Card.

n. Chiropractic Care

The Plan covers care by a chiropractor up to a maximum of 20 visits per Member per calendar year for the treatment of orthopedic and neuromuscular conditions. The following services are covered:

- Initial diagnostic x-ray
- Care within the scope of standard chiropractic practice

For *In-Network* coverage, you do not need a referral but you must obtain services from a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit. This Copayment does not apply to the limit on office visit Copayments described in Section I.A.2. on page 7.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Care outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, or treatment with crystals
- Diagnostic testing other than an initial x-ray

o. Vision Hardware for Special Conditions

The Plan provides limited coverage for contact lenses or eyeglasses needed for certain eye conditions. The coverage and Member Cost provided for these conditions is as follows:

1. Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase and fitting of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is covered in full.
2. Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered in full per year. Coverage of up to $50 per year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per calendar year.

3. Keratoconus. One pair of contact lenses is covered in full per year if there is a medical need. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per calendar year.

4. Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers the full cost of a pair of eyeglass lenses and up to $50 toward the purchase of the frame, or the full cost of a pair of contact lenses.

Prior Plan Approval:

- If you are using a Participating Provider, your PCP or specialist will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider or the treating physician is a Participating Provider and a referral was not received as required, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**, and select Option 4.

Member Cost:

- *In-Network*: No Member charge up to the benefit limits described above.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible up to the applicable benefit limits described above, then Member pays 20% and any balance above the Reasonable Charge.

p. Hearing Aid Coverage

The Plan covers hearing aids at 100% for the first $500 and 80% for the next $1,500 per Member per two calendar year period.

q. Drugs That Cannot be Self-Administered

The Plan covers drugs that cannot be self-administered, including hormone replacement therapy (HRT), when Medically Necessary and administered by your PCP or Participating Provider. Coverage includes drugs that cannot be self-administered that have been approved by the United States Food and Drug Administration, except drugs that the Plan excludes or limits.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

For *In-Network* coverage, your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a referral for the care you need.

r. Clinical Trials for the Treatment of Cancer

The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer under the terms and conditions provided for under Massachusetts law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor, or provider.

For *In-Network* coverage, your PCP will provide or refer you to a Participating Provider for the care you need.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice or a Participating Provider without a referral for the care you need.

Member Cost:

- *In-Network*: No Member charge after $15 Copayment per visit.
- *Out-of-Network*: The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

9. EXCLUSIONS

The Plan does not cover any of the following:

- Acupuncture, aromatherapy, and alternative medicine
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Any form of surrogacy
- Any services not specified in this *Benefit Handbook* and your *Schedule of Benefits*
- Blood and blood products
- Care by a chiropractor that falls outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, treatment with crystals, or diagnostic testing for chiropractic care other than an initial x-ray
- Hospital charges with dates of service after your Hospital discharge
- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this *Benefit Handbook*
- Charges for missed appointments
- Charges for services received after the date on which your membership ends
- Commercial diet plans, weight loss programs, and any services in connection with such plans or programs
- Dental services, except the specific dental services listed in this *Benefit Handbook*. Restorative, periodontal, orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMJ) are not covered. Removal of impacted teeth to prepare for or support orthodonic, prosthodontic or periodontal procedures and dental fillings; crowns; gum care, including gum surgery; braces; root canals; bridges; bonding and dentures.
- Dentures
- Devices or special equipment needed for sports or occupational purposes
- Drugs, devices, treatments or procedures that are Experimental or Unproven
- Educational services or testing, (except such services covered under the benefit for Early Intervention) or services for school performance
- Electrolysis, routine foot care services, biofeedback, hypnotherapy, psychoanalysis, pain management programs, massage therapy (including myotherapy), sports medicine clinics, services by a personal trainer, cognitive rehabilitation programs, and cognitive retraining programs
- Eyeglasses, contact lenses and fittings, except as listed in your *Schedule of Benefits* as well as this *Benefit Handbook*
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Infertility treatment for Members who are not medically infertile
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Personal comfort or convenience items (including telephone and television charges); non-durable medical supplies, unless used in the course of diagnosis or treatment in a medical facility or in the course of authorized home health care; exercise equipment; electronic and myoelectric artificial arms and legs; and derotation knee braces; and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft
- Physical examinations or services for insurance, licensing or employment purposes which are not otherwise Medically Necessary
- Planned home births
- Preventive dental care
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Rest or Custodial Care
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal) and the costs of achieving pregnancy through surrogacy

- Sensory integrative praxis tests
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn for up to 30 days after the newborn's birth
- Services for cosmetic purposes, except as described in this *Benefit Handbook* for post-mastectomy services or reconstructive surgery
- Services for non-Members and services after membership termination
- Services for which no charge would be made in the absence of insurance
- Services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law
- Services for which you are legally entitled to treatment at government expense. This includes services for disabilities related to military service
- Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you
- Services that are not Medically Necessary
- Mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health
- Therapeutic molded shoes, and foot orthotics, except for the treatment of severe diabetic foot disease
- Transportation other than by ambulance
- Transsexual surgery and all related drugs and procedures
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- Preimplantation genetic testing and related procedures performed on an embryo
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Sclerotherapy for treatment of spider veins
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting

C. STUDENT DEPENDENT COVERAGE

When your eligible Dependent child goes to school away from home, he or she is still covered by the Plan. The Plan coverage works one of two ways for student Dependents, depending on where they get care while they go to school.

1. STUDENTS INSIDE THE ENROLLMENT AREA

If your Dependent child goes to school inside the Enrollment Area, he or she can obtain benefits at the *In-Network* level by choosing an HPHC PCP near school. This PCP manages your child's care just as your PCP does for you for *In-Network* coverage.

The Enrollment Area is a list of cities and towns where Participating Providers are available to manage your care. You may obtain the list of the cities and towns of the current Enrollment Area from HPHC's Member Services Department. HPHC may revise the Enrollment Area from time to time.

2. STUDENTS OUTSIDE THE ENROLLMENT AREA

If your child goes to school and received covered services outside the Enrollment Area, the Plan provides coverage at the *Out-of-Network* level.

All the rules and limits on coverage listed in the *Benefit Handbook* for *Out-of-Network* coverage apply to these benefits.

D. REIMBURSEMENT AND CLAIMS PROCEDURES

The information in this section applies when you receive services from a Non-Participating Provider. In most cases, you should not receive bills from a Participating Provider.

1. CLAIM FILING PROCEDURES

In order to be paid by the Plan, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.) Claims must be submitted to the following addresses:

Claims for Pharmacy Services

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Claims for Mental Health and Substance Abuse Services:

HPHC - Behavioral Health Access Center
c/o ValueOptions
Attn: HPHC Claims
P.O. Box 1770
Latham, NY 12110

All Other Claims:

HPHC Claims
P.O. Box 699183
Quincy, MA 02269-9183

2. BILLING BY PROVIDERS

If you get a bill for a Covered Benefit you may ask the Provider to:

1) Bill us on standard health care claim forms (such as the HCFA 1500 or the UB-82/92 form); and

2) Send it to us at the address listed on the back of your Plan ID card.

3. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a Provider for a Covered Benefit, send receipts from the Provider showing proof of payment.

Here is the information we need to process your claim:

1) The Subscriber's name, address and Plan ID number

2) The patient's full name

3) The patient's date of birth

4) The patient's Plan ID number on the front of the patient's Plan ID card

5) The date the service was rendered

6) A brief description of the illness or injury

7) For pharmacy items, a drug receipt stating: the Member's name and Plan ID number, the name of the drug or medical supply, the drug NDC number, the quantity, the number of days' supply, the date the prescription is filled, the prescribing physician's name, the pharmacy name and address, and the amount paid

Members may contact the MedImpact help desk at **1-800-788-2949** for assistance with pharmacy claims.

Please note that we may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1-888-333-4742**.

4. LIMITS ON CLAIMS

To be eligible for payment, the Plan must get claims within two years of the date care was received. We limit the amount we will pay for services that are not rendered by Participating Providers. The most we will pay for such services is the Reasonable Charge. You may be responsible for the balance if the claim is for more than the Reasonable Charge.

E. APPEALS AND COMPLAINTS

This section explains HPHC's procedures for processing appeals and complaints and the options available to you if an appeal is denied.

1. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a Provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact an HPHC Member Service Representative prior to filing an appeal. (A Member Service Representative can be reached toll free at **(888) 333-4742** or at **(800) 637-8257** for TTY service.) The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

2. MEMBER APPEAL PROCEDURES

Any Member who is dissatisfied with a decision on HPHC's coverage of services may appeal to HPHC. Appeals may also be filed by a Member's representative or a Provider acting on a Member's behalf. HPHC has established the following steps to ensure that Members receive a timely and fair review of internal appeals.

HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance, please call **(888) 333-4742**.

a. Initiating Your Appeal

To initiate your appeal, you or your representative should write or FAX a letter to us about the coverage you are requesting and why you feel it should be granted. (If your appeal qualifies as an expedited appeal, you may contact us by telephone. See Section I.E.2.c. on page 42 for the expedited appeal process) Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. We must get this information within one hundred and eighty (180) days of the denial of coverage.

If you have a representative, including a medical Provider, submit an appeal on your behalf, the appeal must include a statement, signed by you, authorizing the representative to act on your behalf. In the case of an expedited appeal, such authorization must be provided within 48 hours after submission of the appeal.

For all appeals, except mental health and substance abuse services appeals, please send your request to the following address:

HPHC Member Appeals
Member Services Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169.

Telephone: 1-888-333-4742
FAX: (617) 509-3085

If your appeal involves a mental health or substance abuse service, please send it to the following address:

HPHC Behavioral Health Access Center
c/o ValueOptions
Northeast Service Center
433 River Street
Suite 1000
Attn: Complaints and Grievance Coordinator
Troy, NY 12180

Telephone: 1-888-777-4742
FAX: (518) 270-4721

No appeal shall be deemed received until actual receipt by HPHC at the appropriate address or telephone number listed above.

When we receive your appeal, we will assign an Appeal Coordinator to manage your appeal throughout the appeal process. We will send you a letter identifying your Appeal Coordinator. That letter will include detailed information on the appeal process. Your Appeal Coordinator is available to answer any questions you may have about your appeal. Please feel free to contact your Appeal Coordinator if you have any questions or concerns about the appeal process.

b. Appeal Process

The Appeal Coordinator will investigate your appeal and determine if additional information is required. Such information may include medical records, statements from your doctors, and bills and receipts for services you have received. You may also provide HPHC with any written comments, documents, records or other information related to your claim.

HPHC divides appeals into two types, "Pre-Service Appeals" and "Post- Service Appeals" as follows:

- A "Pre-Service Appeal" requests coverage of a health care service that the Member has not yet received.

- A "Post-Service Appeal" requests coverage of a health care service that the Member has already received.

HPHC will review Pre-Service Appeals and send a written decision within 30 days of the date the appeal was received by HPHC. HPHC will review Post-Service Appeals and send a written decision within 60 days of the date the appeal was received by HPHC. These time limits may be extended by mutual agreement between you and HPHC.

After we receive all the information needed to make a decision, your Appeal Coordinator will inform you, in writing, whether your appeal is approved or denied. HPHC's decision of your appeal will include: (1) a summary of the facts and issues in the appeal; (2) a summary of the documentation relied upon; (3) the specific reasons for the decision, including the clinical rational, if any; and (4) the identification of any medical or vocational expert consulted in reviewing your appeal. This decision is HPHC's final decision under the appeal process. If HPHC's decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described in Section 3, below.

If your appeal involves a decision on a medical issue, the Appeal Coordinator will obtain the opinion of a qualified physician or other appropriate medical specialist. The health care professional conducting the review must not have either participated in any prior decision concerning the appeal or be the subordinate of such person. Upon request, your Appeal Coordinator will provide you with a copy, free of charge, of any written clinical criteria used to decide your appeal and the identity of the physician (or other medical specialist) consulted concerning the decision.

You have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and your appeal.

c. Expedited Review Procedure

HPHC will provide you with an expedited review if your appeal involves services which:

(1) If delayed, could seriously jeopardize your life or health or ability to regain maximum function,

(2) In the opinion of a physician with knowledge of your medical condition, would result in severe pain that cannot be adequately managed without the care or treatment, or

(3) Involves the continuation of inpatient services following emergency care.

If your appeal involves services that meet one of these criteria, please inform us and we will provide you with an expedited review.

You, your representative or a Provider acting on your behalf may request an expedited appeal by telephone or fax. (Please see "Initiating Your Appeal," above, for the telephone and fax numbers.) HPHC will investigate and respond to your request within 72 hours. We will notify you of the decision on your appeal by telephone and send you a written decision within two business days thereafter.

If you request an expedited appeal of a decision to discharge you from a Hospital, we will continue to pay for your hospitalization until we notify you of our decision.

To enable us to conduct such a quick review of the expedited appeal, we must limit the expedited appeal process to the circumstances listed above. Your help in promptly providing all necessary information is essential for us to provide you with this quick review. If we do not have sufficient information necessary to decide your appeal, HPHC will notify you that additional information is required within 24 hours after receipt of your appeal.

3. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have your appeal decision reviewed by the GIC.

You may contact the Executive Director of the GIC at PO Box 8747, Boston, MA 02114-8747.

4. FORMAL COMPLAINT PROCESS

A complaint may be filed when a Member seeks redress of any aspect of HPHC's service, other than a denial of coverage. Issues concerning a denial of coverage are handled under the appeals process. If you have any concerns or complaints about your care under the Plan or about HPHC's service, please call or write to:

HPHC Member Services Department
Harvard Pilgrim Health Care
Attn: Member Concerns
1600 Crown Colony Drive
Quincy, MA 02169

1-888-333-4742

We will respond to you as quickly as we can. Most concerns can be investigated and responded to within thirty (30) days.

F. ELIGIBILITY

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of Members and Dependents and effective dates of coverage are determined by the GIC.

1. MEMBER ELIGIBILITY

Eligible employees and retirees of the Commonwealth may join this Plan as Subscribers. Coverage will begin on the first day of the month following the earlier of 1) 60 days of employment, or 2) two calendar months. In general, employees who choose not to join a health plan when first eligible must wait until the next annual enrollment period to join. If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible Dependents, if any, at a later date. This will apply if you:

- Declined this coverage when you were first eligible because you or your eligible Dependent was covered under another group health plan or other health insurance coverage at that time of open enrollment, and you or your eligible dependent has subsequently lost such other coverage; or
- Declined this coverage when you were first eligible, and you have acquired a Dependent through marriage, birth, adoption, or placement for adoption.

Eligible employees and their eligible Dependents may enroll for this off-cycle coverage within 31 days after any of the following events:

- Your coverage under the other health plan ends
- Your marriage, divorce, birth, adoption, or placement for adoption
- The birth, adoption, or placement for adoption of your Dependent child

HPHC will issue identification cards for each enrolled Member within two weeks of receipt of enrollment information from the GIC. The identification card should be presented whenever a Member receives covered services.

a. Residence Requirement

To be eligible for coverage under this Plan, you must live and maintain a permanent residence within the HPHC Enrollment Area at least nine months of a year.

This does not apply to a Dependent child who is:

1. Enrolled as a full-time student, or
2. Enrolled as a Dependent child under a Qualified Medical Support Order.

If you have any questions about this requirement, you may call the Member Services Department. They can give you a current list of the cities and towns in the Enrollment Area.

b. Who is Covered

An individual membership covers the employee only (except for routine nursery care services if the mother only has Individual Coverage and the newborn is not being added to the policy). A Family membership covers the employee and the following enrolled Dependents:

- the employee's legal spouse
- unmarried dependent children up to 19 years of age
- children of unmarried Dependents up to 19 years of age
- and, in some cases, a divorced spouse.

When a dependent child marries or becomes 19 years of age, coverage under his or her parent's Family membership ends at the end of the month following either of those events. Parents are urged to notify the GIC 90 days prior to their child's 19th birthday or earlier if the Dependent has married. Special provisions may be made for coverage for students and Dependent children with disabilities age 19 and over as noted below. Under federal law, coverage may also be extended at full cost (no premium contribution by the Commonwealth) for up to 36 months as noted in the section on Termination, which follows.

c. Full-time Students

Full-time Dependent students age 19 through 23 are eligible to continue coverage through this Plan. Students must contact the Plan to obtain this coverage. Full-time students ages 19 through 23 may be included in Family Coverage after application and confirmation of their status by their educational institutions. Students age 24 and older must pay for full-cost Individual Coverage, with no contribution from the Commonwealth. Student coverage ends at the end of the month in which the student ceases to have full-time status or graduates. Students on school-approved medical leave of absence must contact the GIC to determine their eligibility.

d. Divorced Spouses

Spouses who are divorced from employees who are enrolled in this Plan are eligible to continue group

coverage unless such coverage is precluded by the divorce decree. This coverage continues until either the former spouse or employee remarries. After remarriage of the employee, the former spouse may be eligible for coverage upon the payment of an additional premium, after determination by the GIC of eligibility for such coverage.

1. Federal law

In addition to the continuation of coverage described above, federal law known as COBRA provides eligibility for divorced spouses for a maximum of 36 months of continued group coverage at full cost (no contribution from the Commonwealth).

2. Non-Group Coverage Within the Enrollment Area

A divorced spouse who is no longer eligible for the continuation coverage described above may be eligible to enroll in non-group coverage. This non-group coverage may vary from group coverage both in cost and the level of benefits. You are encouraged to apply for non-group coverage within 63 days of termination of your group coverage to avoid any waiting periods or pre-existing condition limitations. To be eligible you must satisfy applicable state law requirements.

e. Dependent Children with Disabilities

Arrangements may be made to continue coverage for physically or mentally disabled children age 19 and older who are incapable of self-support as of their 19th birthday. Application must be made to the GIC to obtain this coverage. Coverage is subject to GIC approval. If approved, disabled children receive their own identification numbers but continue to be considered part of the Family policy when benefits are determined.

To be eligible, the Dependent child must be unmarried and meet the following requirements: (1) is currently disabled; (2) was disabled on his or her 19th birthday; (3) lives either with the Subscriber or Subscriber's spouse or in a licensed institution; and (4) remains financially dependent on the Subscriber.

f. Retired Employees

Retired state employees, except for participants in the GIC's Retired Municipal Teacher and Elderly Governmental Retiree Program, are eligible to participate in the Plan, if they are not eligible for Medicare. Retired Municipal Teachers and Elderly Governmental Retirees are not eligible to enroll in this Plan.

All retirees eligible for, or enrolled in, Medicare Parts A and B must join a separate GIC plan that covers Medicare-eligible retirees. To determine eligibility for Medicare, you should contact your local Social Security Administration office.

g. Changes in Status

It is the responsibility of the Subscriber to inform the GIC of all changes that affect Member eligibility, including but not limited to, divorce, remarriage of either spouse, marriage of a Dependent, death, address changes, and when a Dependent previously eligible as a student is no longer enrolled in an accredited school on a full-time basis. Members must inform the GIC of these changes by contacting the GIC.

h. Dependent Eligibility

To be eligible as a Dependent under this Plan, a Dependent must be:

1. The Subscriber's spouse or surviving spouse (until remarriage); or a divorced spouse who is eligible for Dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended; or

2. A newborn child of the Subscriber's or surviving spouse's Dependent son or daughter until the earlier to occur of a) the date the parent of such child ceases to be a Dependent of the covered Subscriber or surviving spouse or b) the date the child ceases to be a Dependent.

3. An unmarried child of the Subscriber or the Subscriber's Dependent, by birth, legal adoption (including a child for whom legal adoption proceedings have been initiated), under custody pursuant to a court order, or under legal guardianship, until the age of nineteen (19) years;

4. An unmarried child who depends upon the Subscriber or surviving spouse for support, lives with such Subscriber or surviving spouse, and where there is evidence of a regular parent-child relationship satisfactory to the GIC, until the age of nineteen (19) years; or

5. The orphaned unmarried child under the age of nineteen (19) years who is the surviving Dependent of an Subscriber or surviving spouse, until the age of nineteen (19) years or until he/she is eligible for other group health coverage, whichever is earlier; or

6. An unmarried child who, upon becoming nineteen (19) years of age, is mentally or physically incapable of earning his/her own living, proof of which must be acceptable to the GIC and on file with the Plan; or

7. An unmarried full-time student age nineteen (19) through age twenty-three (23) as determined by the GIC and/or HPHC; or

8. An unmarried full-time student, age twenty-four (24) and older as determined by the GIC and for whom additional premium charge as specified in the contract between HPHC and the Commonwealth is being paid.

i. Adding or Removing a Dependent

Dependents of eligible employees who meet the eligibility guidelines described in this *Benefit Handbook* will be enrolled in the Plan using HPHC enrollment forms or in a manner otherwise agreed to in writing by the Plan and the GIC. Members must notify the GIC no more than sixty days after such change is to be effective unless otherwise required by law. Contact the GIC for information on Dependent eligibility and effective dates of coverage.

G. TERMINATION AND TRANSFER TO OTHER COVERAGE

Benefits under this Plan end if:

- The contract between the GIC and HPHC is cancelled.
- The Subscriber fails to pay the applicable cost sharing.
- The Subscriber is no longer a member of the Commonwealth's eligible group (for example, if he or she leaves state service). If an employee leaves the job, but maintains residence within the HPHC Enrollment Area, he or she will be given an opportunity to continue health plan coverage on a non-group (direct pay) basis, when eligible under the law of the employee's state of residence and when HPHC or its affiliated health plans offer non-group coverage in that state.

You also may be eligible for continuation coverage under the federal law known as COBRA. If eligible, federal law permits the employee to extend his or her group coverage for up to 18 months at full cost to the employee with no premium contribution from the Commonwealth. Following this 18 month extension, the employee may convert to non-group coverage when eligible under the law of the employee's state of residence when the Plan offers non-group coverage in that state. ***Please refer to Exhibit A at the back of this Benefit Handbook for further information regarding COBRA coverage.***

A Member's coverage may also end for any of the following causes:

- Providing false or misleading information on an application for membership.
- The failure to pay required Member Cost.
- Committing or attempting to commit fraud or obtain benefits for which the Member is ineligible under this *Benefit Handbook*.
- Obtaining or attempting to obtain benefits under this *Benefit Handbook* for a person who is not a Member.
- The commission of acts of physical or verbal abuse by a Member which pose a threat to Participating Providers or other Members and which are unrelated to the Member's physical or mental condition.

Dependent coverage under this Plan will cease:

On the last day of the month when a Family member no longer qualifies as a Dependent under the rules and regulations of the GIC (e.g. attainment of age 19 of a minor dependent; marriage of a minor dependent; termination of student status; divorce). In addition to COBRA coverage, your Dependent may be eligible to continue health plan coverage on a non-group (direct pay) basis if he or she resides in the HPHC Enrollment Area and if he or she is eligible under the law of his or her state of residence. The Dependent must apply to the Plan within 90 days of the date coverage terminates or the date the Plan sends a conversion notice, whichever is later. Evidence of good health is not required for non-group conversion coverage. The benefits of the non-group plan are different from those under this Plan.

In all cases where group coverage is extended under federal law (COBRA), as referenced in this section, the premium shall be 102% of the applicable full cost premium (with no contribution from the Commonwealth).

H. WHEN YOU HAVE OTHER COVERAGE

1. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this *Benefit Handbook* will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, home owners insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all HMO and other prepaid health plans, Medical or Hospital Service Corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based upon the Reasonable Charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

When a Member is covered by two or more Health Benefit Plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined before those of secondary plan(s) and without considering the benefits of secondary plan(s). The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary or secondary:

a. Dependent/Non-Dependent

The benefits of the Plan that covers the person as an employee, Member or Subscriber are determined before those of the plan that covers the person as a Dependent.

b. A Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but,

2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time;

3) However, if the other plan does not have the rule described in (1) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this Plan (the "birthday rule") will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPHC has knowledge, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;

2) Then, the plan of the spouse of the parent with custody of the child; and

3) Finally, the plan of the parent not having custody of the child.

d. Active/Inactive Employee

The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

e. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, Member or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

If a Member is covered by a Health Benefit Plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

2. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

When a Member's Plan coverage is secondary to a Member's coverage under another Health Benefit Plan, payment to a provider of services may be suspended until the Provider has properly submitted a claim to the primary plan and the claim has been paid, in whole or in part, or denied by the primary plan. The Plan may recover any payments made for services in excess of the GIC's liability as the secondary plan, either before or after payment by the primary plan.

3. WORKERS' COMPENSATION/ GOVERNMENT PROGRAMS

If the Plan has information indicating that services provided to a Member are covered under Workers'Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, payment may be suspended for such services until a determination is made whether payment will be made by such program. If payment is made for services for an illness or injury covered under Workers' Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, the GIC will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

4. SUBROGATION

Subrogation is a means by which health plans recover expenses for benefits provided where a third party is legally responsible for a Member's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights of the Member to recover against such person or entity 100% of the value of the services paid for or provided by the GIC. The GIC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his or her liability carrier or the Member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The GIC will also be entitled to recover from a Member 100% of the value of services provided or paid for by the GIC when a Member has been, or could be, reimbursed for the cost of care by another party.

The GIC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations. The GIC's right to 100% recovery shall apply even if the recovery the Member receives for the illness or injury is designated or described as being for damages other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

To enforce its subrogation rights under this *Benefit Handbook*, the GIC will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the GIC for which such party is, or may be, liable.

Nothing in this *Benefit Handbook* shall be construed to limit GIC's right to utilize any remedy provided by law to enforce its rights to subrogation under this *Benefit Handbook.*

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5. MEDICAL PAYMENT POLICIES

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this *Benefit Handbook* for services rendered in connection with a covered loss under that policy. The benefits under this *Benefit Handbook* shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this *Benefit Handbook* to Members that are covered under any medical payment policy or benefit are payable to the GIC.

6. MEMBER COOPERATION

The Member agrees to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits under this *Benefit Handbook.* Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by the Plan; b) the execution of any instruments deemed necessary by the Plan to protect its rights; c) the prompt assignment to the Plan of any moneys received for services provided or paid for by the Plan; and d) the prompt notification to the Plan of any instances that may give rise to the Plan's rights. The Member further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

Failure of the Member to perform the obligations stated in this Subsection shall render the Member liable to the Plan for any expenses the Plan may incur, including reasonable attorney's fees, in enforcing its rights under this *Benefit Handbook.*

7. THE PLAN'S RIGHTS

Nothing in this *Benefit Handbook* shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this agreement.

8. MEMBERS ELIGIBLE FOR MEDICARE

A Member who is eligible for Medicare, and for whom Medicare is permitted by federal law to be the primary payer, must be covered by both Parts A & B of Medicare and must assign benefits under both Parts to the Plan.

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payer for Covered Services during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payer. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.

When the Plan provides benefits to a Member for which the Member is eligible under Medicare, the Plan shall be entitled to reimbursement from Medicare for such services. The Member shall take such action as is required to assure this reimbursement.

I. ADMINISTRATION OF THIS BENEFIT HANDBOOK

This section has information about how the Plan is administered.

1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED

a. General Coverage Rules

There are times when Plan membership begins when the Member is already hospitalized. Such hospitalization is covered from the time membership is effective.

b. Newborn Coverage

When a newborn child is a Member, but either the mother is not a Member or a Participating Provider did not perform the delivery, services are covered at the *In-Network* level only if:

- The child is born at a Participating Hospital; and
- HPHC is called within 48 hours of delivery to arrange for an HPHC PCP to manage the baby's care.

Please note that the newborn remains eligible for *Out-of-Network* coverage for services like every other Dependent.

2. MISSED APPOINTMENTS

Providers may charge you for appointments you miss if you do not cancel before the scheduled appointment. You can call the Provider to find out how much advance notice is needed to cancel an appointment. The Plan is not responsible for charges for missed appointments and does not count missed appointments toward any benefit limits.

3. LIMITATION ON LEGAL ACTIONS

Any legal action against the Plan, for failing to provide Covered Services, must be brought within 2 years of the denial of any benefit. This does not apply to actions for medical malpractice.

4. LIMIT ON MEMBER COST

Members are required to share the cost of benefits under the Plan. Such Member Cost is limited as indicated below:

a. Medical

1) ***In-Network*:**

- **Outpatient Services Out-of-Pocket Maximum:** A $15 office visit Copayment applies to the first 15 *In-Network* visits a Member receives each calendar year for any combination of the following Covered Outpatient Services: (1) Office visits (excluding office visits for chiropractor or for outpatient mental health and substance abuse services); (2) Chemotherapy; (3) Voluntary second or third surgical opinions; (4) Cardiac rehabilitation; (5) Infertility services; (6) Early intervention services; (7) Physical, occupational, and speech therapy services; and (8) Emergency care in a physician's office. Then, for the rest of that year, the $15 Copayment is waived for the covered outpatient services listed above.
- **Hospital Inpatient Copayment:** $400 per admission – up to a maximum of 1 Copayment per Member per calendar year quarter.
- **Surgical Day Care Services Copayment:** $75 per admission – up to a maximum of 1 Copayment per Member per calendar year quarter.

2) ***Out-of-Network*:**

- **Deductible:** $150 per Member, $300 per Family per calendar year
- **Out-of-Pocket Maximum:** $3,000 per Member per calendar year

b. Mental Health and Substance Abuse

1) ***In-Network*:**

- **Hospital Inpatient Copayment**: $200 per admission – up to a maximum of 1 Copayment per Member per calendar year quarter.
- **Out-of-Pocket Maximum**: $1,000 per Member per calendar year, $2,000 per Family per calendar year

2) ***Out-of-Network*:**

- **Hospital Inpatient Copayment:** $150 per admission
- **Deductible:** $150 per Member, $300 per Family per calendar year
- **Out-of-Pocket Maximum:** $3,000 per Member per calendar year

Please note:

The Hospital Inpatient Copayments and Surgical Day Care Copayments for medical care accumulate only towards the medical Out-of-Pocket Maximum. The Hospital Inpatient Copayments for mental health and

substance abuse services accumulate only towards the mental health and substance abuse services Out-of-Pocket Maximum.

Deductibles for medical care accumulate separately from the Deductibles for mental health and substance abuse services.

In-Network Out-of-Pocket Maximums include Copayments and exclude prescription drug Copayments and Benefit Reductions. Out-of-Network Out-of-Pocket Maximums includ Deductible and Coinsurance and exclude Copayments, prescription drug Copayments, Benefit Reductions, and any charges in excess of the Reasonable Charge. Separate Out-of-Pocket Maximums exist for medical care and mental health and substance abuse services.

5. ACCESS TO INFORMATION

Information from a Member's medical record and information about a Member's physician-patient and hospital-patient relationships will be kept confidential and will not be disclosed without the Member's consent, except for:

a. Use in connection with the delivery of care under this *Benefit Handbook* or in the administration of this *Benefit Handbook*, including utilization review and quality assurance activities;

b. Use in bona fide medical research in accordance with regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects;

c. Use in education within Participating facilities;

d. Where required by law;

e. Health care payments and operations.

6. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC should be sent to:

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

7. MODIFICATION OF THIS BENEFIT HANDBOOK

This *Benefit Handbook*, the *Schedule of Benefits* and *Prescription Drug Brochure* may be amended by the Plan. Amendments do not require the consent of Members.

This *Benefit Handbook* including the *Schedule of Benefits* and *Prescription Drug Brochure*, constitute the entire contract between you and the GIC.

8. RELATIONSHIP OF PARTICIPATING PROVIDERS AND HPHC

The relationship of HPHC to Providers, other than HPHC employees, is governed by separate agreements. They are independent contractors. Such Providers may not modify this *Benefit Handbook*, *Schedule of Benefits* brochure, *Prescription Drug Brochure*, or any applicable riders or create any obligation for HPHC. HPHC is not liable for statements about this *Benefit Handbook* by them, their employees or agents. HPHC may change its arrangements with service Providers, including the addition or removal of Providers, without notice to Members.

For any questions regarding this *Benefit Handbook*, Members may contact HPHC at **1-888-333-4742**.

9. MAJOR DISASTERS

HPHC will try to provide or arrange for services under this Plan in the case of major disasters. These might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of HPHC facilities or the disability of service Providers. If the Plan cannot provide or arrange such services due to a major disaster, HPHC is not responsible for the costs or outcome of its inability.

10. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

HPHC uses a standardized process to evaluate inquiries and requests for coverage received from internal and/or external sources, and/or identified through authorization or payment inquiries. The evaluation process includes:

- Determination of FDA approval status of the device/product/drug in question;
- Review of relevant clinical literature; and
- Consultation with actively practicing specialty care Providers to determine current standards of practice.

Decisions are formulated into recommendations for changes in policy, and forwarded to HPHC management for review and final implementation decisions.

11. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

HPHC uses clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in

accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice.

HPHC uses the nationally recognized InterQual criteria to review elective surgical day procedures, and services provided in acute care hospitals. InterQual criteria are developed through evaluation of current national standards of medical practice with input from physicians and clinicians in medical academia and all areas of active clinical practice. InterQual criteria are reviewed and revised annually.

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical area. The development process includes review of relevant clinical literature and local standards of practice.

HPHC's Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service. Clinician Advisory Committees work in collaboration with Medical Management leadership to develop and approve utilization review criteria.

12. CERTIFICATE OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Members are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Member's GIC Plan.

The certificate shows how many months of coverage a Member has, up to a maximum of eighteen (18) months. It also shows the date coverage ended. It may be used to prove to a new employer the number of days of "credit" a person has from a prior health plan. If there has not been a gap in coverage of sixty-three (63) days or more, preexisting condition exclusion periods in a new employer's health plan must be reduced by the number of days of coverage shown on the certificate.

The GIC will automatically send this certificate to Members upon termination from the Plan. However, Members may call the Member Services Department at **1-888-333-4742** at any time within two (2) years from the date coverage ended to request a free copy of their certificate from HPHC.

13. DISAGREEMENT WITH RECOMMENDED TREATMENT

Members enroll in the Plan with the understanding that HPHC Providers are responsible for determining treatment appropriate to the Member's care. Some Members may disagree with the treatment recommended by HPHC Providers for personal or religious reasons. These Members may demand treatment or seek conditions of treatment that HPHC Providers judge to be incompatible with proper medical care. In the event of such a disagreement, Members have the right to refuse the recommendations of HPHC Providers. In such a case, the Plan shall have no further obligation to provide coverage for the care in question. Members who obtain care from non-HPHC Providers because of such disagreement do so with the understanding that the Plan has no obligation for the cost or outcome of such care. Members have the right to appeal benefit denials to the Member Appeals Committee (See Section E.2. on page 41).

J. GLOSSARY

This section lists the words with special meaning in this *Benefit Handbook.*

Activities of Daily Living

The normal functions of daily life, including walking, speaking, transferring, bathing, dressing, continence, and using the toilet. Activities of Daily Living do not include special functions needed for occupational purposes or sports.

Anniversary Date

The date upon which the yearly Plan premium rate is adjusted and benefit changes become effective. This date is typically July 1st.

Behavioral Health Access Center

The organization, designated by the Plan, responsible for coordinating services for Members in need of mental health or substance abuse care. You may call the Behavioral Health Access Center at **1-888-777-4742**.

Benefit Handbook (or Handbook)

This legal document, including the *Schedule of Benefits*, the *Prescription Drug Brochure*, and any applicable riders which sets forth the services covered by the Plan, the exclusions from coverage and the conditions of coverage for Members.

Benefit Reductions

Benefit Reductions are the amounts your benefits will be reduced for failure to obtain required Prior Plan Approval or provide Notification for certain services. Benefit Reductions are in addition to any Member Cost amounts and do not count toward the Out-of-Pocket Maximum. Please refer to Sections I.A.4.a. and I.A.5. for a detailed explanation of the Prior Plan Approval and Notification processes.

Coinsurance

The portion of Covered Charges that are the responsibility of the Member. Coinsurance amounts are in addition to the Deductible and any applicable Copayments. The Coinsurance amount is specified in this *Benefit Handbook* and the *Schedule of Benefits*.

Copayment

Fees payable by Members for certain Covered Services. Copayments are payable at the time of the visit or when billed by the Provider.

Covered Services

The health care services and supplies for which a Member is covered at the benefit level provided in this *Benefit Handbook* and the *Schedule of Benefits*. Covered Services under this Plan are described in Section I.B. on page 16.

Covered Charges

Expenses incurred by a Member for Covered Services. Covered Charges do not include any amount in excess of a benefit limit stated in this *Benefit Handbook* or in excess of Reasonable Charges.

Custodial Care

Services that are furnished mainly to assist a person in Activities of Daily Living. Examples of such services include: room and board, routine nursing care, help in personal hygiene, and supervision in daily activities.

Deductible

A specific dollar amount that is payable by the Member for Covered Services each calendar year before any benefits are available under this Plan. The Deductible amount is specified in this *Benefit Handbook* and the *Schedule of Benefits*. In some instances, a Family Deductible applies. Once a Family Deductible has been met in a calendar year, the Deductible is deemed to have been met by all Members in a Family for the remainder of the calendar year.

Each Member must pay the per person Deductible amount for Covered Services each calendar year. The Family Deductible is met when any combination of Members in a Family reaches the Family Deductible amount. No Family Member will pay more than the per person Deductible in a calendar year.

Any Deductible amount that is incurred for services rendered during the last 3 months of a calendar year may be applied toward the Deductible requirement for the next year, provided that the Member has had continuous coverage under the Plan through the GIC at the time the charges in the prior year were incurred. Deductible amounts for all services are considered incurred as of the date of service.

Dependent

A Member of the Subscriber's Family who meets the eligibility requirements for coverage through a Subscriber as agreed upon by the GIC and HPHC.

Enrollment Area

A list of cities and towns where Participating Providers are available to manage Members' *In-Network* care. Members, except for a Dependent child attending an accredited educational institution or a child under a Qualified Medical Support Order, must maintain residence in the Enrollment Area and live there at least nine months of the year. HPHC may add cities and towns to the Enrollment Area from time to time.

Experimental or Unproven

A service, procedure, device, or drug will be deemed Experimental or Unproven by HPHC on behalf of the GIC under this *Benefit Handbook*, *Prescription Drug Brochure* and *Schedule of Benefits*, including any applicable riders, for use in the diagnosis or treatment of a particular medical condition if either of the following is true:

a. The service, procedure, device, or drug is not recognized in accordance with generally accepted medical standards as being safe and effective for use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

   Please note, autologous bone marrow transplants for the treatment of breast cancer, as required by law, are not considered Experimental or Unproven when they satisfy the criteria identified by the Massachusetts Department of Public Health.

b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). This does not include off-label uses of FDA approved drugs.

c. For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et. seq.

Family Coverage

Coverage for a Subscriber and one or more Dependents.

(The) Group Insurance Commission (GIC)

The state agency that has contracted with HPHC to provide health care services and supplies for its employees and their Dependents under the Plan. The GIC is the issuer and insurer of the health care coverage.

Harvard Pilgrim Health Care, Inc. (HPHC)

Harvard Pilgrim Health Care, Inc. is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO) in the state of Massachusetts. HPHC provides or arranges for health care benefits to its Members through a network of Primary Care Physicians, specialists and other Providers. Under self insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the GIC.

Harvard Vanguard Medical Associates (Harvard Vanguard)

Medical facilities providing primary care, specialty care and pharmacy services that are owned and operated by Harvard Vanguard Medical Associates.

Hospital

A facility that is licensed to provide inpatient medical, surgical, or rehabilitative services. A Hospital does not include a Skilled Nursing Facility or any place operated primarily to provide convalescent or Custodial/Chronic Care.

Hospital Inpatient Copayment

A Copayment payable for all inpatient care and Surgical Day Care Services that applies to both *In-Network* and *Out-of-Network* services.

Individual Coverage

Coverage for a Subscriber only. No coverage for Dependents is provided.

Individual Practice

An individual doctor who is under contract to provide primary care to Members.

In-Network

The level of benefits or coverage a Member receives when Covered Services are obtained from a Participating Provider with a referral when a referral is required.

Medical Emergency

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to (1) place the health of the Member or another person in serious jeopardy, (2) cause serious impairment to body function, or (3) cause serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

Medical Group

A group of physicians who are under contract to provide primary care to Members. Some Medical Groups also provide specialty care.

Medically Necessary

Those medical services which are (a) essential for the treatment of a Member's medical condition, (b) in accordance with generally accepted medical practice, and (c) provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition in accordance with generally accepted standards in the medical community.

Member

Any Subscriber or Dependent covered by this *Benefit Handbook*.

Member Cost

The cost of benefits provided under this Plan for which Members are responsible. Member Cost includes Copayments, Coinsurance, Deductibles and any combinations of the same. Member Cost differs by the type of benefit and when services are received by *In-Network* and *Out-of-Network* Providers. The Member Cost that applies to a specific benefit is listed in this *Benefit Handbook* and in the *Schedule of Benefits*.

Non-Participating Provider

HPHC does not have special agreements or contracts with Non-Participating Providers. Therefore, a payment schedule for services received from Non-Participating Providers based on Reasonable Charges has been adopted. When care is received from a Non-Participating Provider, Members are responsible for an annual Deductible, Coinsurance and any amounts in excess of the payment schedule. These financial responsibilities are described in this *Benefit Handbook* and the *Schedule of Benefits*.

Notification

Notification to HPHC is required for certain services when using Non-Participating Providers. Further information about Notification may be found in Section I.A.5. on page 14.

Out-of-Network

The level of benefits or coverage a Member receives when Covered Services are obtained through a Non-Participating Provider or through a Participating Provider without a referral when a referral is required.

Out-of-Pocket Maximum

The total amount of any combination of Copayments, Coinsurance and Deductible payments a Member is responsible for in a calendar year. Once the Out-of-Pocket Maximum has been reached, no further Copayment or Coinsurance amounts will be payable by the Member and the Plan will pay 100% of the Covered Charges for the remainder of the calendar year. In some instances, a Family Out-of-Pocket Maximum applies. Once a Family Out-of-Pocket Maximum has been met in a calendar year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a Family for the remainder of the calendar year.

In-Network Out-of-Pocket Maximums include Copayments and exclude prescription drug Copayments and Benefit Reductions. *Out-of-Network* Out-of-Pocket Maximums include Deductible and Coinsurance and exclude Copayments, prescription drug Copayments, Benefit Reductions, and any charges in excess of the Reasonable Charge. Separate Out-of-Pocket Maximums exist for medical care and mental health and substance abuse services. The Out-of-Pocket Maximum (including applicable limitations) is specified in this *Benefit Handbook* and the *Schedule of Benefits*.

Participating Provider

Providers who are under contract to provide care to Plan Members. Participating Providers are listed in the Provider Directory.

Plan

The Harvard Pilgrim POS plan, a health benefit plan that provides or arranges for health care benefits to its Members. The Plan offers coverage under a point-of-service arrangement whereby Members are provided financial incentives to obtain covered health care services from a Participating Provider, with a referral from a PCP as required. Point-of-service refers to the requirement of choosing a primary care physician (PCP) who is a Participating Provider. The PCP arranges or provides services from other Participating Providers.

Plan Sponsor

The entity that has contracted with HPHC to provide health care services and supplies for its employees and their Dependents under the Plan. The Plan Sponsor is the insurer of the health care coverage. The GIC is the Plan Sponsor of this Plan.

Point of Service

See "**Plan**" above.

Prior Approval Program

The Program to verify that certain Covered Services are, and continue to be, Medically Necessary and provided in an appropriate and cost effective manner. Further information about the Prior Approval Program, as well as a list of procedures and services requiring Prior Plan Approval, may be found in Section I.A.4. on pages 11-14.

Prior Plan Approval

Prior Plan Approval is HPHC's authorization of Medically Necessary services, as required for certain Covered Services. Further information about Prior Plan Approval may be found in Section I.A.4.a. on page 12.

Primary Care Physician (PCP)

A specialist in internal medicine, family practice, general practice, or pediatrics under contract to provide and authorize Members' care. A Member selects a Primary Care Physician at Harvard Vanguard or a health center, a Medical Group or an Individual Practice. The Primary Care Physician may designate other Participating Providers to provide or authorize a Member's care.

Provider

A Provider is defined as: a Hospital or facility that is licensed to provide inpatient medical, surgical, or rehabilitative services; a Skilled Nursing Facility; and medical professionals including: physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialists, licensed mental health counselors, physicians with recognized expertise in specialty pediatrics (including mental health care), nurse midwives, nurse anesthetists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health.

Provider Directory

A list of HPHC affiliated medical facilities and professionals, including PCPs and specialists. HPHC may revise the Provider Directory from time to time without notice to Members.

Qualified Medical Support Order (QMSO)

A court order providing for coverage of a child.

Reasonable Charge

An amount that is consistent, in the judgment of HPHC since HPHC is handling claims adjudication, with the normal range of charges by health care providers for the same, or similar, products or services in the geographical area where the product or service was provided to a Member. If HPHC cannot reasonably determine the normal range of charges where the products or services were provided, it will utilize the normal range of charges in Boston, Massachusetts. The Reasonable Charge is the maximum amount that the Plan will pay for Covered Services.

Subscriber

The person who meets the eligibility requirements described in this *Benefit Handbook* or as agreed by the GIC and HPHC.

Surgical Day Care Services

Outpatient surgery that includes charges for use of anesthesia, operating room and recovery room.

II. PATIENT RIGHTS

This section describes your rights as a patient.

As a patient you are entitled by law to the following patient rights from your health care Provider:

- To request and obtain the name and specialty, if any, of the physician or other person responsible for your care or the coordination of your care;
- To have all your medical records and communications kept confidential to the extent provided by law;
- To have all reasonable requests answered promptly and adequately within the capacity of the treating Provider;
- To obtain a copy of any rules or regulations which apply to your conduct as a patient;
- To request and receive any information a Provider has available regarding financial assistance and free health care;
- To inspect your medical records and to receive a copy of your records for a reasonable fee;
- To refuse to be examined, observed, or treated by students or any other staff without jeopardizing access to medical care and attention;
- To refuse to serve as a research subject and to refuse any care or examination the primary purpose of which is educational rather than therapeutic;
- To have privacy during medical treatment within the capacity of the Provider's office;
- To prompt life-saving treatment in an emergency without discrimination based on economic status or source of payment; and without delaying treatment to discuss source of payment, unless delay will not cause risk to your health;
- To informed consent to the extent provided by law;
- To request and receive an itemized copy of your bill or statement of charges, if any, including third party payments towards the bill, regardless of the sources of payment;
- To request and receive an explanation of the relationship, if any, of the physician to any health care facility or educational institutions if this relationship relates to your care or treatment; and
- In the case of a patient suffering from breast cancer, to be provided with complete information on alternative treatments that are medically appropriate.

If you believe that any of your rights have been violated by a Participating Provider, you have the right to file a complaint with HPHC or its designee. All complaints must be submitted in writing and addressed to:

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

For Massachusetts Physicians:

Board of Registration in Medicine
10 West Street
Boston, MA 02111
(617) 727-3086

For New Hampshire Physicians:

Board of Medicine
2 Industrial Park Drive
Suite #8
Concord, NH 03301-8520

For Vermont Physicians:

Vermont Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106

For Rhode Island Physicians:

Rhode Island Department of Public Health
Licensure and Discipline
3 Capitol Hill
Providence, RI 02908
(401) 222-2231

For Maine Physicians:

Board of License in Medicine
137 State House Station
Augusta, ME 04333

III. MEMBER RIGHTS & RESPONSIBILITIES

This section describes your rights and responsibilities as a Member.

- Members have a right to receive information about HPHC, its services, its practitioners and Providers, and Members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about HPHC or the care provided.
- Members have a right to make recommendations regarding the organization's Members' right and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that HPHC and its practitioners and Providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

IV. CONFIDENTIALITY STATEMENT

HPHC is committed to ensuring and safeguarding the confidentiality of its Members' information in all settings, including personal and medical information. HPHC staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with HPHC's confidentiality policies. HPHC permits only designated employees, who are trained in the proper handling of Member information, to have access to and use of your information. HPHC sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to HPHC's confidentiality and privacy standards.

When you enrolled with HPHC, you consented to certain uses and disclosures which are necessary for the provision and administration of services and benefits, such as: coordination of care, including referrals and authorizations; conducting quality activities, including Member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight reviews, such as accreditation and regulatory audits. When HPHC discloses Member information, it does so using the minimum amount of information necessary to accomplish the specific activity.

HPHC discloses its Members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your *Benefit Handbook*. Whenever possible, HPHC discloses Member information without Member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. HPHC will not disclose to other third parties, such as employers, Member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, HPHC and all of its contacted health care Providers agree to provide Members access to, and a copy of, their medical records upon a Member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

EXHIBIT A

GROUP *HEALTH* CONTINUATION COVERAGE UNDER COBRA

You are receiving this notice because you are covered under the Group Insurance Commission's (GIC's) health benefits program. This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours or employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The employee or former employee dies;
  - The employee divorces or legally separates;
  - The employee or employee's former spouse remarries;
  - A covered child ceases to be a dependent;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

1600 Crown Colony Drive
Quincy, MA 02169

1-800-333-4742
www.harvardpilgrim.org

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